WOMEN, INFANTS, AND CHILDREN (WIC): THE CURRENT CRISIS

HEARING

BEFORE THE

TASK FORCE ON HUMAN RESOURCES

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 27, 1990

Printed for the use of the Committee on the Budget

Serial No. 5–9

U.S. GOVERNMENT PRINTING OFFICE

31–597 ⇆ WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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Public Laws: 101st Congress / 2nd Session / House Hearings / 1990 / File 2

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WOMEN, INFANTS, AND CHILDREN (WIC): THE CURRENT CRISIS

WEDNESDAY, JUNE 27, 1990

House of Representatives,
Task Force on Human Resources,
Committee on the Budget,
Washington, DC.

The Task Force met, pursuant to notice, at 9 a.m., in room 210, Cannon House Office Building, Hon. Barbara Boxer, Chairman of the Task Force, presiding.

Mrs. Boxer. Good morning everyone.

The House Budget Committee Task Force on Human Resources will hold a hearing today on the current crisis in WIC. First I want to thank my colleague Representative Bob Wise from West Virginia, whose idea this hearing was.

When he recommended it to me, I realized I should have thought of it myself because we have to take a look at where this program is going. It is such a good program, we can't afford to see it in trouble.

In 1972, responding to evidence linking poor diets to maternal and child health problems, Congress created the Special Supplemental Food Program for Women, Infants and Children—know as WIC.

In recent years, this program has earned nearly universal accolades for its effectiveness in improving the prospects of nutritionally at-risk children.

Today, this program faces a dire crisis.

The Federal Government projected a 4-percent inflation rate for the entire year; instead, the states have seen food prices rise 8 percent in the first half of the year alone.

What does this mean in human terms?

In Texas it means 27,000 people dropped from the program, while some of the remaining children see their cereal allowances cut. In California, where I come from, it means no more cheese for hungry mothers and babies, while some children see their juice allowances cut.

Keep in mind that these mothers and children have already been diagnosed as nutritionally at risk. Keep in mind that even now, nearly 20 years after it was launched, WIC serves only about 50 percent of the eligible mothers and children.

Today we will hear about the survey taken by the National Association of WIC Directors and released just yesterday, on the exact dimensions of the shortfall and what it will mean from state to

state. Coincidentally, the Food and Nutrition Service announced yesterday that it will use surplus funds to reallocate approximately $9 million among 46 States. I applaud the service's diligence and creativity. However, this reallocation isn't nearly enough. Prior to its cutbacks, California, which will receive a "reallocation" of $1.4 million, faced a shortfall of approximately $14. 5 million. The nationwide shortfall was estimated at $73 million.

This reallocation of $9 million is nothing compared to the $73 million we need just to keep the program where it was.

Even as we come to grips with the funding shortfall, a second WIC crisis is looming. The three formula companies now provide to States rebates averaging $1.25 per can of infant formula. These companies are trying to reduce the rebates to about 70–80 cents per can in new contracts. Because States have been able to use those rebates to add approximately 820,000 recipients, the consequences of a one-third cut in the rebates would be disastrous. The FTC has announced that it is investigating the pricing practices of formula companies, but that will be small consolation to today's WIC mothers and their babies.

These challenges to the WIC Program confront us at a time when the United States is backsliding in major indicators of maternal and child health.

The United States ranks 19th worldwide in infant mortality, 22d in the mortality rate for children under age 5; and 29th in low birthweight births. Today 20 percent of American children live in poverty. My colleague who is here today and the others who will join never thought American in the 1990's would have to live with these statistics.

WIC offers a humane and cost-effective response to these grim figures. We know that $1 invested in the prenatal component of WIC saves as much as $3 in short-term hospital costs alone.

Despite that, WIC only reaches half of the persons eligible. While States are permitted to add their own funds to the program, only nine States and the District of Columbia do so.

The WIC Program owes its success in large part to the extraordinary efforts of a dedicated group of men and women who believe that a civilized society is obligated to provide adequate nutrition for poor mothers and children. In the early 1980's, the Reagan Administration tried to slash this program. When it encountered resistance on Capitol Hill, it commissioned a critic of WIC to prepare a study of the program, expecting that that study would provide a basis for its ideologically driven recommendation. When this exhaustive study was completed in 1985, the Administration refused to release it. After a year it was pried loose, but only after the Executive Summary and chapter summaries had been deleted. The Reagan Administration's motive for trying to suppress the study were immediately evident; the study proved, in the words of the New York Times, that WIC produced "spectacular results."

The study found that, among other things, WIC reduced premature births among high-risk participants by 15 to 25 percent.

These findings were corroborated by a recent study conducted by the Bureau of National Economic Research, which found that WIC is the most cost-effective means of reducing infant mortality, after neonatal intensive care.

Pregnant women and children are crying out for our help. Today we will take a good look at how WIC works, the problems it faces, and what we should do to shore up the program.

Last year I worked unsuccessfully to try to make WIC an entitlement program. I still believe that is the best way to treat this most worthy of programs. We will also discuss more immediate issues, such as the advisability of allowing States to borrow against next year's appropriation, and the need for the largest possible funding increase for fiscal year 1991.

Because WIC is not an entitlement, it owes a large part of its success to the determination of tireless and creative advocates. Now it is their turn to tell us how to protect and expand this critical program.

I am very honored today to have with me several colleagues who care about children and care about people and understand the value of this program. At this time I would like to call on my colleague, Bob Wise, for his comments.

Mr. WISE. Thank you, Madam Chair.

I appreciate very much your holding the hearing today. I might say I appreciate your observations about my idea. I have never seen any response quicker in putting together not only a hearing of a task force, but pulling together two other committees.

Your response on this is the fastest I have seen in the 8 years I have had the privilege of holding this office. I know it is because of your dedication to this program.

On Monday I had the opportunity to visit a WIC center in West Virginia. There the staff is doing the best job they can, but there is going to have to be 2,000 children at least cut off the WIC Program because of the cutbacks. Our State legislature is meeting today and hopefully is going to supplement the money that is needed.

Quite frankly, our State is in a pretty tough fiscal condition, as are many states, and can't be expected to do this on a regular basis. As I sat at the center and watched mothers and their children coming into be evaluated, some of those mothers were going to be told that day that their children could no longer receive WIC.

I thought that was the final irony because the way it is done is that there is really no choice, is that the child is examined. They total up the points, head size, body weight, and so on.

If that child is over a certain number of points, in other words, if the WIC program has been succeeding in getting that child up to where the child ought to be, then the child is cut off.

What kind of emotional as well as physical yo-yo are we as a Federal Government putting people on if we take them on and take them off and say, unfortunately, you are now getting to be where we wanted you to be. Therefore, you to have come off.

I sat with Carlin Sanders and her daughter, Monet. Monet is one year old and is precious. Monet will continue on the program.

However, her 2-year-old sister received notice last year that she will not continue on the program. Ms. Sanders talked about how important the WIC program was for the cereal, peanut butter, juice and other things. Ms. Sanders has a job but does not have the money to buy all the foods that are so necessary.

The 1-year-old sister stays on and the 2-year-old sister comes off. There is an irony there to the fact that we want children to become

healthy. When they start to begin to reach that goal, then they are cut off.

I hope the West Virginia Legislature and the California Legislature and the Texas Legislature and all the others in the 30 States having to contemplate cutbacks won't have to in the future. And those legislatures which also are having to wrestle with can they allocate their own resources to let this program go on.

I would hope as the Federal goal we can say we believe children, particularly in their earliest stages, and pregnant women, that these people are entitled to basic nutrition. As a Congress, we are willing to come up with the resources.

There are three problems to deal with. One is the level of funding. In West Virginia you are only reaching at best 35 percent of those eligible. We only work up to the top three priorities.

In fact, it is the third priority that the children are being cutback from now. The first is overall funding. The second is then making sure that the WIC Program covers those eligible for it so that it serves all those who have the need.

Then the third program is one that needs to be discussed also not only in this proceeding, but perhaps in other proceedings. That is the issue of the formula rebates. In West Virginia, as across the country, we are seeing the formula manufacturers drop the rebate that they are willing to give the states.

What is that going to mean? It is going to mean more Monet's or more sisters of Monet cut off because that money was being plowed back in to expand the caseload. When the rebate drops, that amount that is paid to the states for every can of formula used and purchased, when that rebate drops, that means less people that can be served. There are many issues to visit on WIC.

It looks like in West Virginia we are going to, because of the state legislature, hopefully be able to get by until October. The question is where do we go from there?

This Budget Committee recommended a roughly $150 million increase hoping that would expand the caseload. We find that will not only not expand the caseload, that will barely keep us up with what the current services are and, indeed, there are going to be a lot more people still going unserved.

Finally, I would just like to say, Madam Chair, that this is not the first cutback in the WIC Program. Indeed, in my State, and I know it is true in other States, that there have been cutbacks in the past.

So, we have a situation where it is you are on, you are off, and it has a very debilitating effect to the system. I have got to believe in this country, Madam Chair, that we can say to children, You are not going to lose your cheese. You are going to be entitled to more than 1 ounce of cereal and that you don't have to have a juice cutback.

I hope we can do that for the Monet's of this country. Thank you.

Mrs. BOXER. Thank you, Mr. Wise.

It is my honor and privilege to call upon now the Chairman of the Select Committee on Children, Youth and Families. I don't think many people know that he is really the father of the WIC Program because back in the 1970's, it was George Miller who fought to make the WIC Program a permanent program.

Now that the WIC Program is going through a crisis, I can think of no other person that I would rather be cochairing this hearing with than Congressman George Miller of California. Mr. Miller?

Mr. MILLER. Thank you very much.

I thank you for holding this hearing. I think it is important that we raise the visibility of exactly what is taking place with respect to the women and infants and the children served by this program.

As you know, and as every Member of Congress knows, this is an immensely popular program in the Congress because of the benefits that we derive and the votes for this program. Yet we now see it languishing for a lack of funding to provide adequate care to those individuals.

I would just hope that this hearing would result in fast track legislation to take care of this problem. We have some legislation in the Education and Labor Committee that we hope to consider very quickly and/or a supplemental to provide the necessary moneys for the WIC directors to take care of their caseload.

People ought to recognize finally that this is more than nutrition because in many areas where WIC programs have the ability and have the resources, they also provide the kind of health education, pregnancy education, drug education that also pays great benefits to pregnancy outcomes and to the mothers and to infants. I understand that you have called to make this program an entitlement. It should be.

It should be one of the very basic rights in our society that we have healthy pregnancies and healthy children.

Tragically these pregnancies are not able to stop while we have problems with our fiscal year. We wait on supplemental funding resolutions and pregnancies go on.

All we do is risk pregnancies that go on and result in damaged children. We really need not tolerate that situation and it is not necessary in this society.

I thank you and all the Members for your interest in this program and holding this hearing.

Mrs. BOXER. Thank you very much, Mr. Miller.

Congressman John Bryant has been a strong supporter of children since he came to Congress with me in 1982. In his State there are some terrible problems. We are hearing that about 27,000 people have been removed from the program.

Mr. Bryant, we welcome you and we ask you to make an opening statement.

Mr. BRYANT. Thank you, Madam Chairwoman. I want to say how much I appreciate your willingness to call this hearing. Also I would like to identify myself with your opening remarks.

I would just observe, as you did, that apparently as early as next week 27,000 women and children will be cut from the Texas program, which at the present time only provides an average of about $33 a month for food and baby formula, which is probably not enough money to feed a German shepherd dog.

Yet, they are going to take that many people off of it. It is only serving about 17 percent of the eligible people in Dallas County today, and that number will be reduced down to 16 percent, as I understand it, with the upcoming cuts.

I think we have some questions to ask this morning, one of which is, Why is the Administration urging us to pass an emergency supplemental appropriations bill without additional funding for WIC? I am sure if the Contras had run out of money the Administration would be right up here asking for money from Congress.

If there was some shortfall in another of the Administration's favorite projects, they would be up here asking for a special appropriations bill for those projects. But they are not up here asking for one for WIC. I think that is the basis for the most important question we ought to be asking this morning.

I am glad you are having this hearing.

Mrs. BOXER. Mr. Bryant, I couldn't agree with you more. It is my privilege to call on Jack Buechner, our Republican colleague.

Mr. BUECHNER. Madam Chairman, I would like to commend you for holding this hearing on the Special Supplemental Assistance Program for Women and Infants and Children, which we also call WIC.

As you noted, this program is truly at a crisis stage. On May 31, the Washington Post reported almost 40 State governments are cutting back on WIC, "because of rising milk, orange juice and cereal prices." The article went on to note that "one state has been forced to reduce the cereal allowances for 1- and 2-year-olds from 36 ounces a month to 24 ounces a month, and they will soon be forced to drop 27,000 participants."

Recently while touring a people's health center in my district, I was informed Missouri consistently runs out of WIC money at least 2 to 3 months before the end of the cycle.

For the workers of the center, the situation is, of course, frustrating. But for the program's participants, it is devastating. Such shortfalls place these people at risk for malnutrition and anemia, thereby leading to fewer healthy mothers and children than we all would like.

Madam Chairwoman, these problems are occurring despite the fact that WIC has been and continues to be a very effective program. In fact, the available evidence indicates that there are few Federal programs which serve the requirements of the truly needy quite as efficiently as the WIC Program.

Yet, too many of those who are eligible are left outside the ring of support because of funding constraints. To begin to address the problems, approximately 250 of our colleagues have requested that WIC be funded at $150 million over the current services level, a position which I strongly support.

There is an ad about oil filters which says you can pay me now or pay me later. The WIC Program takes a small amount of money and saves people from being at risk. When we place at-risk children and profile them down the line, what we as a nation pay for their medical care, education and in many cases ultimately for addiction and incarceration, we can all go back and take a look and see if we pay now, we will save a heck of a lot later. Thank you.

Mrs. BOXER. Thank you. Mr. Espy, a member of the Task Force.

Mr. ESPY. Thank you, Madam Chairwoman.

I appreciate the opportunity to be here this morning. I also wanted to join those others who have congratulated you for calling a hearing to expose problems in this worthy program.

Yesterday we heard Nelson Mandela. We witnessed his very eloquent discussion to the Congress and to the American people. Mr. Mandela relayed the hopes and aspirations of the African people who are struggling for democracy. He also stressed that the people of Africa are fighting for an economy that can provide food, houses, education, health services, social security and, quote, "Everything that makes human life human, that makes life joyful and not a protracted encounter with hopelessness and despair."

Though Mr. Mandela spoke about Africa, the vision he expressed, the hopes he articulated, Madam Chairwoman, are also our own.

We are here today to address the current crisis in the WIC Program, a program which has proven to be one of the most successful programs that our country provides. As Mr. Mandela put it, to assure the life of our children is not in protracted encounter with hopelessness and despair.

Despite the success of WIC research by the Select Committee on Hunger, among others, reveal shortfalls may force the termination of thousands of poor women and children before the end of this fiscal year.

On a nightly news show last night, it was reported as many as 240,000 or so will be forced to come off the program. So despite the success of WIC heralded by everyone having an opportunity to review it, the bottom line aspects of this program, if Congress and the Administration fail to take the steps to counteract increases in food prices and other factors causing the shortfalls, thousands of infants and children will lose the nutritional support which we know can make the difference between growing up as happy, healthy children or otherwise growing up as children plagued by illnesses.

There is a cliche that an ounce of prevention is worth a pound of cure. However, it seems funding pressures are already forcing many WIC programs to focus only on those children and mothers in the highest priority.

Those indeed at the highest risk. So if we fail to do more, then we will only be ensuring that thousands of more children will suffer in the long run.

If we fail to serve more, then WIC will no longer carry out our mandate to prevent nutritional problems before they occur.

I welcome each of our panelists to this hearing. I welcome the opportunity to learn more about the situation that our WIC directors are coping with and the country. I am also happy to find out this morning that the situation in Mississippi is not as bad as others around the nation.

Also I look forward to hearing testimony about how budgetary decisions we can reverse, we can make now can reverse this trend of WIC serving less women and children and more and more eligible women and children being forced to wait in waiting lines which may never end.

Fully funding and extending WIC to all eligible women and children, Madam Chairwoman, must be one of our highest priorities. I welcome this hearing because this is not just a question of health of the children who are denied WIC. It is the question of the health of our Nation. Thank you.

Mrs. BOXER. Thank you for drawing that analogy with Mr. Mandela's comments. As I sat there, it went through my mind that I wish that our country would be the complete model for Mr. Mandela.

Obviously we are the model of democracy, but we have these problems and we have got to meet these challenges.

Joining us now, the third cochair of this hearing, and I think this shows the dedication of Members to come here, the third cochair of this hearing is Tony Hall of Ohio, chairman of the Select Committee on Hunger, who has looked at the problem and has a remedy that he is discussing. It is my privilege to call upon Congressman Hall at this time.

Mr. HALL. I want to thank Chairwoman Boxer and Chairman Miller for calling this important hearing this morning.

The subject, of course, is the WIC Program and the services it provides to women and children who are at health and nutritional risk. The only thing between many of these women and anemia and malnutrition is the WIC Program.

Back in April, the Select Committee on Hunger received a phone call from a congressional office discussing funding problems in Texas. We called the WIC directors in all 50 States and learned, in fact, that thousands of women and children were being terminated.

The fact is, as I am sure has been reported here, the Administration revealed a nationwide shortfall affecting 34 States and totaling $67 million. Worst of all, it has been found that more than half the States were beginning to actually drop eligible women and children from the program.

I am a supporter of the WIC Program. My first hearing as chairman of the Hunger Committee was on the National WIC Evaluation and establishing, finally, just how effective WIC was in reducing infant mortality, increasing maternal weight gain, increasing head size, and generally improving the nutritional status of participants. I have seen the evidence that WIC saves $3 in health care costs dollars for every dollar spent.

I don't understand how we can have a program that is as beneficial as WIC is, as cost efficient as WIC is, and deny it to half the people who need it. I don't understand how we can bail out the S&L administrators—at a cost of $500 billion—and we can't find a fraction of that money to feed women and children.

I introduced legislation yesterday—the WIC Services Restoration Act—that would provide a quick-fix to the crisis in State WIC programs, allowing them to use surplus funds this year being turned back in some cases from States without being penalized and allowing the WIC directors to borrow against next's years 1991 appropriations figures to make up the shortfall and put the children back on the program.

I am anxious to hear from our witnesses today what they think about this legislation.

We will never be able to really solve the problem until everybody recognizes this fact: WIC ought to be available to everybody who needs it.

We don't send only half our children to school, we don't give only half our children clothing or shelter. There is no reason that only half of the children eligible for WIC should get a nutritious diet.

I supported an increase of $150 million above current services for this program and I have testified on that proposal in the budget process. As a matter of fact, such language is in the budget now. What we were hoping to do with the $150 million, of course, was to expand the people eligible next year.

We want to go well beyond the 50 to 60 percent of people that are eligible and currently receiving benefits. The fact is, right now, if we continue to go with the trend that we have, that $150 million probably will only keep us even in maintaining caseload.

We need to do better than that. The priority of women and children in this country that have been determined by medical professionals to be at risk should probably be the highest priority of this land.

Yet it is not. I think it is incumbent upon all of us—among our colleagues and among the people in this room that care very deeply about this issue—to make it the highest priority possible.

So for that reason, I am very thankful for the hearing that has been called, Madam Chairwoman and Mr. Miller, Thank you.

I associate myself with Mr. Espy and everybody else that is here that has made comments on your great support. Thank you.

Mrs. BOXER. Thank you so much, Chairman Hall. I would say three Stealth bombers can double this program, if you want to put it in those terms.

At this time I would like call forward Betty Jo Nelsen, Administrator of the Food and Nutrition Services, U.S. Department of Agriculure.

Welcome. I know you have a statement and perhaps you would like to read it or summarize it.

Just for the Task Force and my cochairs to know, we have just two panels after this witness. We are hoping to go through this hearing in half a day.

Will you proceed, Ms. Nelsen, for 5 minutes. Then we will ask questions.

STATEMENT OF BETTY JO NELSEN, ADMINISTRATOR, FOOD AND NUTRITION SERVICE, U.S. DEPARTMENT OF AGRICULTURE, ACCOMPANIED BY JAN LILJA, DIRECTOR, FNS OFFICE OF ANALYSIS AND EVALUATION AND RON VOGEL, DIRECTOR, SPECIAL SUPPLEMENTAL FOOD PROGRAM

Ms. NELSEN. Thank you.

I would thank you for the opportunity to be here to talk about the WIC program and share information that we have with you and work cooperatively with you to address these problems.

I brought with me this morning, and I would like to introduce Jan Lilja, the Director of FNS Office of Analysis and Evaluation, and also Ron Vogel, the Director of the Special Supplemental Food Program for Food and Nutrition Service here in headquarters in Washington. I brought them with me in anticipation that some of your questions may be technical in nature and you deserve answers as best we can prepare them because we want to give you all the information that we have.

I am somewhat limited in my abilities, having assumed the post of FNS Administrator 5 months ago. We are here to answer your questions.

I am very grateful for this opportunity. I commend you for holding this hearing, Madam Chairwoman, because I think that any time we can share information and go to the root of the situation, the outcomes will be better than anyone could have expected.

The Bush Administration has demonstrated its support for the WIC program by making it a priority in the last two Federal budgets. In 1990, as you may recall, in the budget message, the President spoke about putting more money into high priority programs like WIC. In 1991, the budget that is currently before you, WIC received funding to continue the level of services, and with a 4 percent increase from what we anticipated inflation to be at that time.

I appreciate this opportunity to share our concern and tell you about the management strategy for this important program. We have been working cooperatively since March with State WIC agencies and local programs to address the problems resulting from the unexpected increase in food prices.

When we survey the WIC Programs across the Nation, these are our findings: First, high priority pregnant and breast-feeding women and high priority infants enrolled as of March 1 will continue to be served.

New applicants in these high priority areas are being accepted today except in one or two States.

Unspent funds totaling $11 million, as is our customary procedure at this time of year, have been reallocated to help States deal with the problem. It will not be enough for all States to return to normal.

Three, while some States experienced declines from peak caseload, as many as 20 will increase and maintain their current caseload. Actually, in WIC we have had with your help another record year. In 1989, there were $4.1 million participants served in the WIC Program. In 1990 we anticipate that the average participation rate for the Nation will be 4.4 million, which is an increase of 6 percent.

And finally, we have sent out a directive to the regional offices to provide WIC participants who no longer are recertified information about the Food Stamp Program so that we are certain that everyone gets the benefits that they are deserving of.

Madam Chair, at the start of this fiscal year, no one could have predicted the events leading to higher food costs. Food price inflation is significantly higher for citrus products and for dairy products, which form the major part of the WIC package.

But I would also like to talk to you about the other variables in the WIC Program in addition to the food costs. First of all, these variables make it very hard for State agencies and for local program operators to run the program.

When food packges are given out, there is no certainty people will actually use the food coupons. The variable there is they don't know how many of those food coupons are going to be used and what amount of money will lapse in that process.

A second variable is caseload mix. When program operators set their caseload expectations at the beginning of the year, they don't

know how many people are going to be women, pregnant women, infants or children. The cost of the food packages vary. So it is like the principal who ends up with too many third graders, and they say now we need another teacher. That happens to WIC directors.

The savings from the formula rebates is another variable. The difficulty in forecasting participation and then allocating the proper amount to administrative costs presents another variable.

I want to make certain you know that the number of significant variables in the WIC Program makes the management for the State and local level very, very difficult, and at times frustrating when things occur outside the control of the staff and impact adversely on the clients.

Our role at FNS is to try to forecast as many of those variables as we can and predict significant changes in advance. Sometimes, as with this food price increase, like our forecasting does not measure up to the need. It moves faster than we can properly predict. Both FNS and the WIC State agencies have dealt well with the latest price increases and learned important lessons for the future.

According to FNS data, we are currently serving almost all eligible infants. We are currently serving 90 percent of the eligible pregnant women.

I am cognizant of the time, Madam Chair, and I am trying to move quickly through my testimony.

Mrs. BOXER. If you can complete it in a minute, I will appreciate it.

Ms. NELSEN. The kinds of things WIC agencies are doing to try to bring down the cost of the food package without compromising the nutritional elements of the food package include the use of generic brands, substitution such as milk for cheese and the purchase of larger, more economical sizes. Working with the States, we believe we have managed the program so that all clients at medically related nutritional risk, have been served.

I want to talk about looking ahead. We plan to hold a meeting in July in which we will invite interested folks to come together to talk about a WIC specific inflation index which we hope will help us in the future to predict rising food costs in a better manner. We want to work with State agencies to improve their management information systems and their forecasting on their caseload mix.

I must, in closing, remark that even in the best of times when food prices are stable and formula rebates secured, the WIC Program is difficult to manage. 1990 has been such a difficult year.

I can't end my testimony without commenting on the great job that has been done at the local level both by the program operators and also by the clients. When you talk with people who have been served through the WIC Program, you know the only way that they have been able to bring the cost of the food package down has been with the cooperation of the clients who have been willing to go out and purchase cheaper brands to lower cost of food because they realize that that will benefit others.

Thank you, Madam Chairman. I would be pleased to answer questions.

[The prepared statement of Ms. Nelsen may be found at end of hearing.]

Mrs. BOXER. Would you say this program is in an emergency state right now?

Ms. NELSEN. Well, I think that I would characterize it as a very difficult situation. I really don't quite know what you mean by "emergency."

Mrs. BOXER. What do you think is an emergency? Do you think it is an emergency when 27,000 people are shut out of the program in Texas and when the California program no longer has cheese in it?

Ms. NELSEN. No; I have to tell you that I think that I would characterize this program as being in a severe crisis and an emergency if we were not able to serve pregnant women and infants with medically related nutritional risks. That would be my definition of an emergency.

Mrs. BOXER. So this Administration does not think this program is in an emergency situation?

Ms. NELSEN. No; I think we would characterize it as a very difficult situation. It has caused hardship for some clients. But we believe that what we have done with the money that Congress provided to us is focused the available funds on the highest priority needs.

Mrs. BOXER. What about the people, the 50 percent of those kids and mothers who are receiving no coverage at all? Is that an emergency?

Ms. NELSEN. Well, the WIC Program is a supplemental program.

Mrs. BOXER. I understand.

Ms. NELSEN. And our very basic program, as you know, is the Food Stamp Program.

Mrs. BOXER. I understand.

Ms. NELSEN. And Congress recognized a few short weeks ago when you provided a supplemental appropriation to us for that program that we have had very high participation increases in the Food Stamp Program.

Mrs. BOXER. Do you think it is a problem that 50 percent of the eligible people for the WIC Program are not getting served by the WIC Program?

Ms. NELSEN. I think it is a problem that the money doesn't stretch that far. And our number is 60 percent.

Mrs. BOXER. Do you think there ought to be money so every eligible child and woman is covered?

Ms. NELSEN. We think this is a high priority program for this Administration.

Mrs. BOXER. Is it a high priority program when the budget came in at current services?

Ms. NELSEN. Absolutely.

Mrs. BOXER. What is your definition of priority? In other words, it is a priority and the program came in at current services with not even enough to meet the inflation cost. Is that your definition of a priority?

Ms. NELSEN. My definition of a priority in this 1991 budget was anything that did not get a cut was clearly a priority.

Mrs. BOXER. Anything that didn't get a cut?

Ms. NELSEN. That is right. We have had a very tough struggle, as you all well know, with Federal resources. So I think that a program that came in maintaining the baseline with no cut, plus pro-

viding for what was thought to be at that time the proper increase for inflation, was clearly a priority.

Mrs. BOXER. Okay. Do you think there ought to be an emergency supplemental so that people don't get thrown out of the WIC roles?

Ms. NELSEN. That would be certainly the best of possible worlds if we had more money.

Mrs. BOXER. Are you requesting we go forward with a supplemental and the approach that Mr. Hall is recommending to us?

Ms. NELSEN. The problem, Madam Chair, is that because of the WIC funding formula, we would need a tremendous amount of money over the specific problem amount of money because we have all—Congress and FNS and also the WIC agencies, agreed that when money is distributed, it should be distributed equitably to people in all States, that you don't single out States where there are problems.

If you do that one time, then you have problems in subsequent years with people who don't try to manage effectively.

This is a grant program, and we work very hard——

Mrs. BOXER. Let me interrupt you here. Mr. Hall has an approach to this that could solve the crisis or, as you put it, the extreme difficulty. Would you support such an approach?

Ms. NELSEN. We would like to work with Mr. Hall.

Last night at 5:30 we received a copy of the bill. We would like to provide you with an analysis of that bill and offer you suggestions on it. We think there are good things about it. We also think there are pitfalls.

We would like to share that information with you.

Mrs. BOXER. When would you have that prepared, do you think?

Ms. NELSEN. We can do it by the end of today.

Mrs. BOXER. Very good.

[In reference to the information referred to above, the following statement was submitted:]

This was overcome by events in that the Committee on Education and Labor reported H.R. 5149 prior to the completion of the Budget Committee's Task Force hearing.

Mrs. BOXER. Let me just point out that this Administration came forward and asked us for $420 million for Panama and $300 million for Nicaragua. And I think that our children deserve an equal shot.

I am disappointed on the one hand you said in your testimony that this is a priority, and on the other hand you define a priority treatment as requesting current services. That is a little bit of a difference between us. Mr. Hall.

Mr. HALL. Often in the past couple of weeks I have continued to receive queries as to how the problem developed. Who is at fault. Of course, I have not pointed the finger because I am not quite sure.

But one of the things that really concerns me is the operations of the Department of Agriculture. To what extent could you have kept the States better informed of the impending inflation that occurred?

Ms. NELSEN. I would like to defer that question, Mr. Hall, to the staff director because when the problem first surfaced, we began

discussing it more than once a week in my office at the end of February or the first of March.

We have been paying a tremendous amount of attention to the process of working with States and communicating with our regions to enable them to work with States to tackle this problem.

But perhaps Mr. Vogel has some knowledge before that time that he could add to that for you.

Mr. VOGEL. Congressman Hall, as Ms. Nelsen has said, as soon as we were aware ourselves that the dairy price situation was as bad as it turned out to be, we tried to work immediately with our State agencies to let them know that this had come upon them.

What our problem was in working with our economic research folks in the Department of Agriculture, the message was that this was a short-term problem, that we could expect some moderation, and it wasn't necessarily a cause for concern as we kept checking with the economists over there.

And just like Ms. Nelsen said, it caught us all by surprise when the prices continued to spiral upward and there was no moderation in sight.

We have committed with State operators to explore alternatives in looking at WIC inflation in the future. We hope one of the lessons we have learned from this experience is that we need to do as much as possible, as early as possible, to check out the accuracy of the inflation information that we have received.

Mr. HALL. We can't continue to have this situation crop up again. What steps does the Department have for preventing such problems in the future?

Ms. NELSEN. We want to meet with interested parties and talk about developing a WIC specific measurement of increasing food costs, to be able to do that rationally and also to be able to do that in regions.

Sometimes food costs will vary region by region. We plan over the summer to analyze what kind of tools we would use to develop such a WIC specific measurement and whether that is a good idea of not.

The issue of improving management information systems in individual programs and in State agencies is a key one. I described to you some of the variables with participation and the number of food coupons they use.

All of that interacts with this cost factor for the total program. So what we need to do is to look at States that may now be having a very difficult time and ask ourselves if they had better information systems in place where they could gather the information from the local programs around the State, would they, in fact, be better able to predict sooner what was going to happen and send a message out sooner.

I think, Congressman Hall, that you would agree that if we can know how far our money is going to stretch and don't sign up people for a program when we have to then turn around and the first time they are re-certified, drop them from the program. We would be better off not to be overly aggressive in looking to increase at the participation beyond what we can handle in a current year. That is what management information systems will do for you.

Mr. HALL. We hope you will continue to be aggressive, though. I think the one thing that Congress is saying is to get a program in place so we can improve our awareness of these impending problems.

The program works. The fact is that infant mortality rates are declining and health care access and nutrition status of the women and children that are at-risk in this program are increasing, as you know. We have had hearings, reports on it. It is a tremendous program.

Members in the Congress support it, which leads to another question. Because a number of the States are reducing the amounts of calcium and vitamin C-rich foods, our concern is how are we going to assess the effectiveness of the program on these women and children that are now going to get less nutritious foods.

Ms. NELSEN. We have underway, as Congress has requested us to do, a study on the impact of the WIC Program on children. Ms. Lilja is the director of that office. They have been working very hard to define that study. That will be the place where we will get that additional information. If you would like, she could describe that to you.

Ms. LILJA. The WIC Child Impact Study will study the effect of WIC on infants and children. It will study impact on diet intake, growth and development and use of development services. We are field testing two research designs that we hope will lead us into the direction of getting conclusive evidence on this program. One approach will use vital statistics to compare groups of WIC and non-WIC infants.

The second approach will test whether unserved WIC eligible pregnant women can be randomly assigned to WIC and non-WIC groups.

We are proceeding right now with two field tests for that study.

Ms. NELSEN. In the short term, Congressman Hall, the directive that we have sent out to State agencies is, as much as possible, they should make substitutions in food packages and not cut things out of food packages. So, for example, that is why you find increased milk in the food vouchers in California as the cheese was removed.

That is a disappointment to people because they would rather eat cheese than drink milk. In fact, the nutrient value is the same for those folks.

Likewise, we have had to drop peanut butter in some places, which is, as you know, something that kids like a lot. We have substituted beans, which I suppose is something they don't like so much.

But the fact is that the nutrient value of the food packages with these lower cost foods will stay the same as best we are able to.

So, we are not really eliminating from the food package for the kids who are still in the program any of the nutrient components.

Mrs. BOXER. Thank you. I would like to put into the record here that although you are saying there is no effect from what is happening, in today's Washington Post, the Director of the Oklahoma program says that it takes 6 months for anemia to show up in lab tests. And she said before the anemia becomes apparent, children with inadequate nutrition are already beginning to experience less

resistance to disease, reduced levels of alertness and other reactions to inadequate diet.

It appears as if there is some conflict with your point that the kids are getting the nutrition that they need and there has been no adverse impact. Because of his time schedule, I would ask unanimous consent that I can call on Mr. Bryant.

He has a minute or two left of questions.

Mr. BRYANT. Thank you, Madam Chairwoman. I have a bill with regard to which the hearing is commencing at 10 o'clock this morning in another committee.

It occurs to me it is an emergency when you don't have enough to eat or your kids don't have enough to eat to be healthy. I think it would be a lot more refreshing had you simply answered Chairwoman Boxer's question, yes, we have an emergency on our hands. For 27,000 in Texas, that is the case. I understand that will be the case for 240,000, 250,000 Americans. Why you are not willing to characterize it that way is beyond me. You began to be aware of this problem in February or March. Is Secretary Yeutter aware of this problem?

Ms. NELSEN. Yes.

Mr. BRYANT. The Administration is aware of it. Is the Administration going to come forward and ask for a supplemental appropriation for WIC or not?

Ms. NELSEN. It is my understanding the supplemental request was already submitted to Congress and has been met by Congress. It includes, I think it was $1.2 billion for the Food Stamp Program, $3.1 million for the CSFP. There was no money included for the WIC program.

Mr. BRYANT. Did you ask for it?

Ms. NELSEN. Specifically, the only money that we asked for was the money to address the real emergency that we had in the Food Stamp Program.

Mr. BRYANT. You did not ask for it?

Ms. NELSEN. Not for the WIC Program.

Mr. BRYANT. The Administration knew about it in February or March. You have not asked for it. As far as you know, you have no plan to ask for it; is that correct?

Ms. NELSEN. That is correct.

Mr. BRYANT. Does that bother you?

Ms. NELSEN. I am troubled by the fact that some eligible children originally included and anticipated being part of this program, have had to be dropped from the program because there are not sufficient funds.

But, Mr. Bryant, there is another problem, too. There is another problem because right now today we are serving 60 percent of the eligible people in the United States on this program. It is a grant program.

We manage the best we can with the money that we receive. We are pleased the Congress has been as generous as they have and that we have, in fact, increased the participation from 4.1 million people to 4.4 million people this year. That is a 6 percent increase this year. We are very pleased to have accomplished that.

Mr. BRYANT. Does it bother you that these people are not going to get what they need in order to be healthy?

I can't believe you are not going to say, yes, it bothers me. It is a problem, and I have argued within the Administration.

Ms. NELSEN. It bothers me that it is a problem.

Mr. BRYANT. Have you argued for more money within the Administration?

Ms. NELSEN. At FNS we have discussed at great length measures we could take to address this problem.

Mr. BRYANT. Have you told them that you need more money? Have you asked Secretary Yeutter to seek more money so he could serve these kids and these pregnant mothers?

Ms. NELSEN. No.

Mr. BRYANT. Thank you.

Mrs. BOXER. Thank you, Mr. Bryant. Mr. Wise.

Mr. WISE. Thank you, Madam Chair.

Ms. Nelsen, several questions. I will try to move very quickly.

The statistics you use about actually saying in some areas you have increased, the WIC caseload has increased. I would assume that is in the first priority level. But, is that at the cost of other priority levels? In an era of declining money, a WIC dollar has to be stretched further, I know how we are adding people over here.

What I see in West Virginia is maybe we are adding some in Priority I but we are cutting them off in Priority III.

Ms. NELSEN. I think that is an accurate representation, Mr. Wise. As we have identified, this is a problem. Within this set amount of money that we have, we have talked about how can we re-direct funds to serve those in greatest need. I think that is a strategy, a management strategy that you would encourage us to have.

We want to make sure the resources that are available are going to the people who are hurting the most. If you want to direct us to do something differently, I would be pleased to hear that.

Mr. WISE. My only concern is I don't want to leave this hearing with the impression that WIC caseloads are increasing overall because they are not. They are being cut back.

It is just where there are increases, somebody else is getting cut off to make room for somebody in Priority I. I am not arguing with you. My concern overall is that the best in West Virginia, and I notice in testimony from other States they are getting maybe up to the third priority level out of seven or eight priority levels.

There are a lot of people not being served, which brings me to my second question. The figure 60 percent being served seems kind of high in light of the fact that the statistics I have seen from my own State seem far less than that. I wonder whether we are an anomaly in your opinion or whether there are a lot of other States that are not meeting 60 percent?

Ms. NELSEN. There is a wide range of participation level among States, some are at 75 percent, some are at 25 percent. So, there is a wide variety in the way that States are participating in this program.

I think there is also an interesting thing that I didn't have time to talk about in my testimony, but you may want to consider. That is, there is a wide variety of eligibility criteria so that a person can be eligible for the program in one State and not be eligible in another State.

This is not a program like the Food Stamp Program where we have a national standard. It is very difficult for you to compare yourselves with others around the table, Mr. Wise, and talk about your State because you are talking about apples and oranges.

Mr. WISE. In your testimony, you talk about the variables that have come on, particularly food inflation. From a budgetary standpoint, do you have any projections on what the changing of rebates is going to mean? Have you put together any figures about how much more Congress is going to have to come up with to keep this program at last at current services?

Ms. NELSEN. First of all, we don't have any figures for you because there have not been enough new contracts. After the first four, we were terribly distressed.

Then there was one State—I thought it was Texas—where they had a good answer from the companies and they got a good response. I may have the State wrong. They did better than others. But that gave us hope that we weren't going to see a uniformly sublevel of infant formula rebates.

What I would like to say to you on that subject is we are monitoring it closely. We would like to continue to provide information to the Chair and Members of Congress about what is happening with formula rebates so that you will be as current as we are on that subject.

That is another issue that falls in the category of "beyond control."

It is very troubling not only to the program, but to those of you who want to be able to count on a stable WIC Program.

Mr. WISE. As Mr. Hall pointed out, my concern, and I know his concern, is the approximately $150 million Congress put in, the Budget Committee assumed, hopefully, to increase the caseload, given the food situation, we will be lucky to hold even.

Given the rebate situation, it seems we are falling much farther behind, and I think to the tune of a couple of hundred million dollars on the rebate situation alone. Is that correct?

Ms. NELSEN. I don't think it is just the rebate. That could play a piece of it. But you characterize it accurately, yes.

Mr. WISE. Have you put together any projections of what it would take to keep WIC at the current services level for fiscal year 1991 given what is happening presently in food and in—with some consideration given to rebates?

Ms. NELSEN. I would like to give you a rule of thumb. The rule of thumb is that for each 100,000 additional participants, it costs an extra $50 million. So, I think the reason I would like you to know about this rule of thumb, which is what we use until something really goes amuck, like the formula rebate, that you could use that rule of thumb in your own work in trying to design what you think is a good level of funding for this program.

Mr. WISE. May I extrapolate from that then. If the figure is accurate, there would be about 240,000 people cut off. In order to get them back on, do we need to start at least at $125 million just to get them back?

Ms. NELSEN. If you are talking about the $150 million that the House budget resolution has already passed, I believe it would take another $127 million.

Mr. WISE. My time is up. I would encourage you—and I realize that one thing you are not talking about, I think, out of tact, is your situation with OMB in which you have got to run things not only through the Secretary, but through OMB. OMB doesn't have to look at a 1-year-old child asking for cheese. I wish they did sometimes.

I guess what I would ask is, if you would, as you make your projections, keep this committee informed. I think there is going to be a day when we have to come back fairly soon and re-visit the area of WIC and re-visit the assumptions not only of this committee, but, of course, of all the other committees, including Appropriations.

Right now I think we are looking at a several hundred million dollar shortfall. That is a rough extrapolation.

I would like to have some solid figures to work with.

Ms. NELSEN. Mr. Wise, we would be pleased to share any information we have as we develop it with you. I think, Madam Chair, that is going to be essential, that in coming up with a budget figure for the 1991 budget, we are going to have to keep in very close contact because of these variables.

Mrs. BOXER. Well, you offered your budget for 1991, but what we are looking for is how we are going to make it through with those budget numbers.

At this time, I want to note that we have been joined by Congressman Durbin, a member of this Task Force, and Mr. Emerson, who is the ranking minority member of the Select Committee on Hunger, and Mr. Geren, who is going to participate in the next panel.

To expedite matters, first, I am going to call on Mr. Buechner, then Mr. Espy and Mr. Emerson, then Mr. Durbin. Then we are going to move on to the next panel.

Mr. BUECHNER. Ms. Nelsen, going back to the article that the Chair wanted put in the record, I would remind everyone that the headlines said, "Food Costs Curb Nutrition Program," and that the Administration has no control over increased costs of any of the products. In fact, that is what was not anticipated; is that correct?

Ms. NELSEN. That is correct.

Mr. BUECHNER. Also, I believe that it is true that the Congress has traditionally appropriated less than was assumed in the budget resolution in this program. Isn't that also correct?

Ms. NELSEN. I don't know the answer. Yes.

Mr. BUECHNER. I would like you to elaborate a little more on your remarks—you didn't get a chance to really complete it because you were concluding your original opening testimony—about the various States and the participants have all agreed that if there are increases in the program that there will be an equality sharing as opposed to simply picking up the shortfall in States that maybe are not up-to-speed administratively.

Could you elaborate on that?

Ms. NELSEN. I will. The States where the problem occurs have a very real problem. It is very difficult to put the money just into those problem States. We have all agreed, FNS, WIC State agencies, local program operators, all people concerned about this program, that any time you fund this program, it should be distribut-

ed through a funding formula that ensures that every State is treated equally.

There is a great consensus on that. And what we want to caution you about is not to—please not to do things that will interrupt that funding formula because it has been something that, I think, has made everyone know that they had to operate to the best of their ability.

If we begin to develop an idea that when there is a problem, we will give money specific to the problem areas, then the folks who have worked really hard to manage their program or who have had just blind, dumb luck and managed their program well so they don't have a problem, will be penalized for it. We don't want that to happen.

The funding formula and the integrity of that is very important to this program. We would urge the Congress not to do something that would put that at jeopardy. When we look at Mr. Hall's bill, that is one of the things we will provide you with information about as to whether or not we think that would occur.

Mr. HALL. Would the gentleman yield on that?

Mr. BUECHNER. I really don't have much time, Mr. Hall. I would yield. Go ahead. That is all right.

Mr. HALL. I just want to follow up on the legislation that you mentioned. I think that if, in fact, we want the appropriation, we would have to appropriate a fairly large amount of money to work within the framework of the existing allocation formula.

But under this proposed legislation, it would be up to the WIC directors to decide—it probably would affect about 34 States—on what they would need to go back to March 1 caseload levels. So each State would be treated equally.

Two, as I listen to you, the bill would solve the problem that you are dealing with. This legislation would allow that. We are not talking about going to the Appropriations Committee. We are not talking about appropriating any additional money this year.

Ms. NELSEN. We will take that into account in our analysis.

We will be looking at that. Then we will say to you in our analysis that comes back, this wouldn't make any problem with the funding formula. That is what I meant to say.

Mr. BUECHNER. Reclaiming my time.

I would like you to just hit on one more thing. Then I will yield back. That is the issue, you said that when cheese was cut out, for instance, the California program, that there was additional milk provided so that on a nutritional scale, the nutritional amounts were equal?

Ms. NELSEN. That is correct.

Mr. BUECHNER. You really don't need to do a study to find out whether or not there is an impact of dropping cheese out because your nutritionist advises you as long as there is X amount of calcium and fat in the diet, that that is sufficient. So it may not be as appealing to the recipient, but from a nutritional standpoint, there is at least a comparative; is that right?

Ms. NELSEN. That is correct.

Mr. BUECHNER. I thank you very much. I recognize that we can argue all day long about the semantics of what is the difference be-

tween an emergency or a crisis or whatever. But I would also like to compliment you in this respect.

That the States' people that I have talked to, the local WIC people, have never expressed that there was any lack of compassion on behalf of the program, that it did encourage efficiency. And I know that no one in this Nation, whether they are a liberal or conservative or Republican or Democrat, Easterner, Westerner, wants to see a hungry child not receive nutrition.

At the same time, we are the ones that give you the bucks and the directives. Hopefully, we can stretch it out. The price of prunes in Palo Alto is not something you have got control over. Thank you.

Mrs. BOXER. Mr. Espy.

Mr. ESPY. Thank you, Madam Chairwoman.

The Administration has shown some support for this program, certainly more support than the last Administration. I compliment them for that. I also sympathize with you because you have been there about 5 months. You stepped into a hornet's nest with regard to this program. But I have to say that I am also disappointed with the reaction to the question as to whether or not this was an emergency.

I really think it is. I think respectfully that we all think that it is in a larger context because the United States of America, a country with a $200 billion budget, although with many problems, we rank 17th among industrialized nations in keeping our children healthy, in reducing the high incidents of infant morality and making sure babies weigh more at birth. That means other countries, Great Britain, France and Spain and even those less industrialized, Malaysia.

You talk about Cuba, Cuba is doing better than we are doing in the United States in keeping our babies alive.

In that context alone, I think it is an emergency, and I think we can do a whole lot better with WIC and other programs for this reason.

I don't have much time and I want to ask two questions. One, Mrs. Boxer, in her opening statement and Mr. Hall, as chairman of the Select Committee on Hunger and a lot of us have talked about making this program an entitlement. I am not sure I got your response to that. What is your response to making this an entitlement which pretty much is a function of eligible participants?

Ms. NELSEN. Mr. Espy, I would caution you before you make that move. It has to do with the issue I raised earlier. In the National School Lunch Program and the Food Stamp Program, which we administer, there are national standards of eligibility. It is the same from one State to the other.

Before you talk, I think, or at the same time that you talk about entitlement, you really need to confront that issue of developing a national standard so that people are treated uniformly across the United States the same way. We don't want people to move from one State to another and lose their eligibility.

An entitlement implies that all people are going to be eligible. I think we have to nail down that eligibility standard before any move to entitlement.

The second caution——

Mr. ESPY. If I could just respectfully interrupt and say couldn't we work together on drafting these standards?

Ms. NELSEN. We would be very pleased to do that. I think before we go into that hornet's nest, which I must caution you and you may hear from the WIC directors about this being a hornet's nest, is that the States have a lot of latitude from the Federal Government on this subject.

Before you decide we may be able to draft an eligibility standard, I think we want to ask the other participants, the local programs and the WIC directors, to join us in that effort.

Mr. ESPY. Thank you. I would invite you to let's go ahead and try to draft these standards so we can move toward making this an entitlement.

The second question, in your testimony you were saying a lot of this had to do with unanticipated inflationary costs with respect to food prices. I guess as a response to my good friend from Missouri's question, I know that we cannot control food prices. We don't want to control food prices. But I can say to you that this Administration and this Congress through agricultural policy can impact food prices. I think that has been the problem in the past with the disasters that we have had, with the fact that the crops have become more scarce and, therefore, farmers, you know, can offer them to a more private market.

They have gone up. We have just finished the 1990 agricultural bill, at least in the main committee. It has yet to come to the floor.

Have you requested an analysis of what 1990 agriculture bill will do to food prices, will do to eligible products with respect to WIC? I say to you, in my opinion, we have done a lot to freeze target prices.

If you look at the Senate and the House bill, there is some variation with regard to loan rates, but we all freeze target prices. We have done a little bit with flexibility, but we have done nothing with regard to the cost of production, which is increasing all the time.

So something has to give. What I think is going to give is we have got a lot of farmers going out of business, but also a lot of food prices are going to increase. Have you asked for an analysis from USDA as to the impact of this on the WIC Program?

Ms. NELSEN. No, but you can bet your boots that by 11 a.m. this morning I will certainly be contacting the Economic Research Service at USDA and asking them to do that for us.

Mr. ESPY. I would like to say put the boots on and hurry up and ask for that. As we sit here talking about unanticipated inflationary price increases with regard to the WIC Program is going to go up in 1991, 1992.

That is something those of us who serve on the Agriculture Committee, Mr. Emerson and Mr. Durbin on Appropriations, I think have to be cognizant of that as well. We passed it on the Agriculture Committee side. It is going to have an inflationary impact. We have to let them know.

Ms. NELSEN. As soon as we get that analysis, I will be pleased to let you know.

Mrs. BOXER. Thank you. Mr. Emerson.

Mr. EMERSON. Thank you. I have a statement I would like to submit for the record.

Mrs. BOXER. Without objection, so ordered.

[The prepared statement of Mr. Emerson may be found at end of hearing.]

Mr. EMERSON. I think Mr. Espy and Ms. Nelsen have had a very useful colloquy here. I wish to associate myself with that colloquy.

Mr. Espy's questions and Ms. Nelsen's assurances of working with the appropriate committees of the Congress to resolve this crisis or emergency or problem, must be addressed.

I have long been a strong supporter of WIC. I continue to be a strong supporter of WIC. I intend to be a strong supporter of WIC into the future. I think it is one of the best investments this country can make in addressing health care problems before they occur—certainly in addressing the problems of infant and childhood nutrition.

I also want to say, and I don't wish to be redundant here this morning, but the bottom line here is that this problem, crisis or emergency was generated because of rising milk costs essentially and then a freeze in the orange groves which drove the price of orange juice up very extensively.

I have regretted hearing here this morning some implication that the Administration has somehow been negligent in its intent to address this problem. As a member of the Nutrition Subcommittee of the House Agriculture Committee and as the ranking Republican on the Select Committee on Hunger, I have personally worked very diligently to see that these kinds of issues are not politicized. I would not like to see this issue politicized at this time.

With Ms. Nelsen's assurances that she will work with the appropriate committees of the Congress in addressing the sensitivities that are involved here and the very real problems that are related to inflation and food prices, I would hope that we might get on with the business of resolving the problem and do a little less talking about it and a little more work.

I yield back the balance of my time.

Mrs. BOXER. Mr. Emerson, I appreciate your positive comments. On the other hand, I think it is important we not skirt the issue, which is that we do have a problem, call it a crisis or an emergency.

As you point out, it doesn't matter what we call it, the issue is what do we do now that we know about it. Some of us feel the Administration isn't doing enough. Others on your side have great confidence that this will be resolved. I think the purpose of this hearing is to find out what the problem is now that we know about it and what are the plans.

Mr. Hall put forward a proposal to solve the problem. This afternoon we are going to find out if the Administration supports it. As of this time we don't know that. We do know there has been no request for a supplemental to deal with this. And I think if you got irritated perhaps at the Chair for feeling a little frustrated, I apologize, but that is the way I feel. Mr. Durbin.

Mr. DURBIN. Thank you, Madam Chairwoman.

First let me confess a certain bias here. As a Member of the Appropriations subcommittee which works with the USDA and par-

ticularly with the WIC Program and many other nutrition programs through the USDA, it has been my experience over the last 6 years to sit in our Appropriations subcommittee room across from tables with people, men and women representing the Administration speaking to these programs. After having tolerated for 4 years the conservatives being sent to us by President Reagan's crew, it is such a breath of fresh air to have Ms. Nelsen and her people come before us. Though we do disagree on some policy issues, I do believe her heart is in the right place.

I felt her candor and honesty in dealing with our committee has been a welcome change from what we were used to before. I am hoping we can continue a very positive relationship in the future. I am confident that we can.

I also want to address this morning some of the comments Ms. Nelsen has made and give her an opportunity perhaps to address them. I am troubled by some of the things you have said. I don't know if it is part of the professional courtesy between USDA and OMB that you don't hang your dirty laundry here at these hearings, but honest to goodness, not to characterize this as an emergency, not to suggest that anyone in your department is asking for additional money to deal with this problem, to suggest that this is a high priority program because it wasn't cut in the President's budget, it just doesn't sound consistent with what I believe to be your real attitude toward the importance of this program.

I would like to ask you at this time if you would like to perhaps comment on what has been said earlier in some of your comments? They don't sound consistent with what I heard you say before our subcommittee.

Ms. NELSEN. The problem, Mr. Durbin, I think, in part comes from talking about next year's money and the priority that we would assume for 1991 and then the part of dealing with the current situation. My view of my job is that I have been hired to manage the Food and Nutrition Service and administer this program, which means I work a lot to stay within the appropriation that has been given to us to make sure that we follow the principles and the policies that have been established by the Congress and the Administration.

So I really haven't gone much beyond trying to cope with the frustration and the disappointment that comes from unanticipated food cost increases, quite frankly. We have talked a lot about would more money help. We have, on the other hand, had to weigh what the real cost would be because the real cost is a lot higher than just to solve the problem because of the funding formula.

Mr. DURBIN. Would more money help?

Ms. NELSEN. Obviously, but it would take a lot more.

Mr. DURBIN. Do I assume at some point in the budget process folks from OMB or USDA come to you and ask you whether you need more money?

Ms. NELSEN. Well, no one has ever put it that way in this Administration. I read the Washington Post, too, and I don't think anybody is asking if we would like more. Of course, we would say yes.

Mr. DURBIN. Of course—ever to make a budget request?

Ms. NELSEN. Yes, we put it in for 1992. We put it in there and are going to ask for a heck of a lot of money that came through.

Mr. DURBIN. Are you suggesting no one in your operation asked for more money to deal with this problem?

Ms. NELSEN. We discussed it. Then we weighed it against what it would really cost in terms of the equity funding across the board. We decided it would be bad to ask. So the answer is no.

Mr. DURBIN. Isn't there some real cost to the fact that the high priority kids who are not being served by this program because of the increase in food prices will soon become, I should term that differently—the kids in the priorities IV, V, and VI who are not being served because of the high cost of food will soon become kids in Priority I because of the difficulties of they are going to have with anemia and nutritional deficiencies?

In other words, this is a short-term savings. Not spending the money this year means that next year, guess what? More kids are turning up in Priority I. Then what are we faced with? Have we saved anything by denying these kids basic foods and nutrition?

Ms. NELSEN. If your assumptions are correct, yes.

Mr. DURBIN. Does it sound logical and consistent to you what I just said?

Ms. NELSEN. For certain situations. For the sake of argument and not to take everybody's time, I could give you that. I could argue with you on that point.

Mr. DURBIN. If you concede that point to me, it makes all the more reason for you to stand up and shout in your meeting with OMB put us in this supplemental. We are going to have poor kids who are not going to have the chance to be served by WIC who next year are going to be sick kids, what the following year will be kids near death.

Maybe that is an exaggeration. I hope it is. If this program is worth anything to us, we have to fight for it at every level. I want to hear from you that you are fighting for it when it comes to supplemental appropriations. Earlier you said you weren't.

Ms. NELSEN. I didn't ask for it because of this weighing factor that I described to you. I don't know what Congress did because I was not on the scene and don't know what you did when the supplemental came before you and you passed it.

I know a lot of things were added. We didn't ask for that $3.1 million in CSFP that we got. We were managing that program very well. I don't know what consideration was given to WIC when you had a supplemental before you, quite frankly.

Mr. DURBIN. Well, I hope after this hearing that if the occasion ever arises where there is conversation with OMB that you will say that you join us in feeling that more money needs to be put into this program because of unanticipated food price increases.

I might add to you to say this program is a high priority because President Bush didn't cut it doesn't ring true with me. I am sorry.

When we have 30 and 40 percent increases in the space station, 30 and 40 percent increases in the Moon to Mars missions, 30 and 40 percent increases in super colliders, I am sure each of these projects would be a great source of pride to this Nation.

But it would be a greater source of pride to this Congressman and many Members on the Task Force to say, Guess what? We are not the worst in the world on the infant death mortality rate. We

have made some real progress there. I hope you will join us in providing for those funds.

Ms. NELSEN. I will join you in providing accurate and timely information so that as the Congress has to make a decision on the 1991 budget, we can join you in having WIC be a high priority.

I think everyone faces very difficult problems in this next budget.

Mr. DURBIN. Thank you, very much. Thank you, Madam Chair.

Mrs. BOXER. Thank you, Mr. Durbin.

Ms. Nelsen, I want to thank you for coming here. You were the recipient of a lot of frustration. I would urge you to think about one thing you said here, which was be careful of the hornet's nest. Every State must be treated equally. And think about every child being treated equally. When you think about this as an entitlement program, that is what we would do. We would get away from this notion of how do we handle Mississippi versus California versus Illinois versus Ohio.

It is not too difficult to figure out what standard because there is no difference between what a pregnant woman needs in Mississippi, California or anywhere else. If we begin thinking that way, we get out of this bureaucratic mindset of let's be fair to each State. I am really hopeful that as a result of this hearing and the bipartisan nature of it in terms of the strong support you hear from both sides of the aisle, that you will go back and analyze Mr. Hall's approach.

It would be my fervent dream that this Administration would support it. It is a short-term fix, but it will help children. And we will be able to move forward hand in hand and then look at the kinds of issues that Mr. Espy raises and Mr. Emerson raises in terms of the future of this program. We want to thank you very much for your candor here today.

Ms. NELSEN. Thank you. It has been a pleasure.

Mrs. BOXER. Dennis Bach, Robert Greenstein, and David Paige. Mr. Bach is the president of the National Association of WIC Directors. He is the WIC director from the State of Iowa. Mr. Greenstein is the executive director of the Center on Budget and Policy Priorities. Dr. Paige is from the School of Public Health, John Hopkins University.

We would ask each panelist to keep his remarks to 5 minutes. We will be glad to enter a complete statement into the record.

We will call on Mr. Bach, president of the National Association of WIC Directors and the WIC director of Iowa, first. Welcome.

STATEMENT OF DENNIS H. BACH, PRESIDENT, NATIONAL ASSOCIATION OF WIC DIRECTORS AND WIC DIRECTOR, STATE OF IOWA

Mr. BACH. Congresswoman Boxer, Congressman Hall, Congressman Miller and other Members, I appreciate the opportunity to appear before you today. I would like to express my appreciation to Congressman Miller for his work in securing 240 signatures on a Dear Colleague letter to the Appropriations Committee supporting an increase in WIC funding for the coming year.

Mrs. BOXER. Please speak up. It may be my age, but I am having a hard time hearing you.

Mr. BACH. Normally I don't have a problem with people hearing me. Today is an exception.

The National Association of WIC Directors is the organization that represents State and local agency management of the Supplemental Food Program for Women, Infants, and Children. The goals of NAWD are to improve the management of the WIC Program, serve as a resource to its members, and do whatever is necessary to serve the interests of our clients. The people we serve are low income, nutritionally at risk pregnant, post-partum, and breastfeeding women, infants, and children up to the age of 5.

There are two significant features of this population which should be kept in mind throughout the discussions which follow today. First, this is a particularly vulnerable population. WIC infants and children are at a critical stage of growth and development. Their nutritional well-being during these years affects their potential for physical and intellectual growth and development throughout their life.

Second, it is a population that is critical to the future of this country. Recently, the Council on Economic Competitiveness issued a report detailing their priorities for the Nation. At the top of the list, along with reducing the deficit, was support for increased funding of the WIC Program. This recommendation was prompted by their concern over whether this country would have a sufficient supply of healthy, productive workers 20 years in the future. They recognized the vital role that WIC can play in insuring that productive workforce.

WIC is designed as an intervention program. During this critical period of an infant or child's development, we provide nutritional supplements, education on how to maintain a healthy diet throughout life, and encouragement for ongoing health care. And then, when the child is no longer at nutritional risk, we go on to serve someone else.

The converse to this is that there is an opportunity cost for every child that is not served. If the Government wants to build a highway or a jet plane but decides is cannot afford it this year, the Government can wait and build it next year. However, an infant or young child cannot wait until the Government decides it can afford to feed it. If the funding for the WIC Program is sufficient to serve only 60 percent of the eligible population, the Federal Government will pay the opportunity cost of not serving the other 40 percent.

There will undoubtedly be testimony today regarding WIC's effectiveness in reducing future health care costs. Suffice it to say that prevention of health problems through the WIC Program is less expensive than correction. We are currently reducing the prevention aspect of the WIC Program.

The WIC Program is not an entitlement. Each year Congress weighs its priorities and then budgets and appropriates what it feels it can for the WIC Program. Those funds are provided to the U.S. Department of Agriculture which allocates them to the various States. State WIC Program managers then take those funds and stretch them to serve as many participants as possible. And that brings us to the heart of today's issue. Because of factors

largely beyond the control of State managers, the existing funds cannot be stretched to serve as many participants as they were intended to. The fiscal year 1991 budget resolution passed by the House expressed the intent to provide $150 million above the level theoretically necessary to maintain the current services. However, the current services amount identified in the budget resolution will not be enough to support the existing caseload. At lease one-third, and possibly all of the additional $150 million will be consumed by increases in the cost of the WIC food package. That situation will be compounded by a decline in infant formula rebate revenues, if that occurs.

Our association recently completed a survey of States to determine what has been happening with food package costs. The results are summarized in a report which is included as an appendix to this testimony. I will not go into great detail of the findings, but will instead emphasize a couple of points from that survey.

The average increase in the cost of the WIC food package for just the first 6 months of fiscal year 1990 was 7 percent. This is almost twice the increase USDA projected for the entire year. Some of the main culprits in this increase have been dairy prices and orange juice prices. As a result of this, we estimate from our survey that 25 States that would be reducing their caseload by upwards of 240,000 participants, a quarter of a million participants. More recent information gathered by our colleagues from the Center on Budget indicates that number is probably low and it may be closer to 280,000. I believe Mr. Greenstein will go into that in more detail.

We have had numerous discussions with our colleagues from the advocacy community, our State directors, staffs of Congress, Members of Congress, present company excluded, that have said the possibility of a supplemental appropriation this year was out of the question. We would like to go on record as an association in asking that Congress consider that. I have been heartened to hear as much discussion this morning as I have.

Several States have reduced the quantity of WIC foods provided. While some restrictions on participant choice and some tailoring of quantities to meet nutrition needs is proper, we are concerned that escalating cost pressures may drive States to take these measures to extreme, the long-term detriment to the program will far outweigh the short-term savings. WIC will not be effective if a child will not eat the types of cereal available. WIC will not be effective if the value of the WIC food package is diminished to the point that a mother doesn't bother to come into the clinic anymore to get her WIC checks. We want to make sure that cost-cutting tricks are not seen as the primary solution to the current caseload dilemma.

We are also concerned about the recent trend in bids on infant formula rebate contracts. Rebate levels have steadily escalated during the last 2 years. Many of us predicted that they would eventually peak, fall somewhat, and then level off. I don't believe any of us would have predicted that they would fall as far and as rapidly as they have recently.

Mrs. BOXER. Please conclude.

Mr. BACH. We have an indication that there is an emerging pattern of decline in those rebates. Approximately 20 percent of the

WIC caseload is supported by those rebate funds, which means there is a potential of even greater problems in the coming year.

I would like to make one final point. The decreases occurring this summer are unfortunate and for those directly affected by it, they are tragic. To understand the problem, you have to go beyond the numbers and the report and the numbers being talked about currently.

Some States are not reducing caseloads because they already have had restrictions in place. There are approximately 41 States that do not serve the priorities. The situation will not be stopped until there is sufficient funding to serve the eligible population.

Mrs. BOXER. I am going to have to ask you to stop at this point. I am afraid we are going to run over our time.

[The prepared statement of Mr. Bach may be found at end of hearing.]

Mrs. BOXER. Mr. Greenstein, welcome.

STATEMENT OF ROBERT GREENSTEIN, EXECUTIVE DIRECTOR, CENTER ON BUDGET AND POLICY AND PRIORITIES, ACCOMPANIED BY STEFAN HARVEY, DIRECTOR OF THE SUPPLEMENTAL FOOD PROGRAM PROJECT

Mr. GREENSTEIN. Thank you for the opportunity to appear here today. The WIC Program has a striking record in its impact on improving maternal and child health.

Before going into the current situation facing us, I did want to draw to your attention something we recently came across, which was a relatively recent study by the National Bureau of Economic Research, whose president is Martin Feldstein, that found WIC to be the second most cost-effective method we have of reducing infant mortality surpassed only by prenatal care. That is the kind of finding that makes the situation we address today so tragic.

In the last several weeks both the National Association of WIC Directors and the Department of Agriculture conducted state by state surveys to give us the latest information on exactly what is happening. We have analyzed those surveys over the past week. As Dennis Bach indicated, the association survey found 25 States cutting people off the program and that those 25 States would cut 242,000 people off between March and September.

The department survey found 26 States cutting almost the exact same number, about 239,000 off. The department survey found those States that were cutting were cutting 9,200 people apiece. I might add that an earlier survey, that the Hunter Committee conducted had a smaller number, I think 55,000 people. That was an average monthly reduction from one month to the next. The figures we are looking at now are the total number of people removed from March to September. When we looked at the department survey and the association's survey, we did find some discrepancies in maybe eight states.

Over the last 5 days we have called those States to get the latest information and resolve the discrepancies. Unfortunately, what I have to report to you today is the latest and I think best numbers are that now 27 States are reducing their caseload by a total of 280,000.

The reason our results are a little higher than either the association survey or the USDA survey are, one, not every State responded to the association survey. There were about three, several additional States that were cutting that USDA picked up. Second, there was a problem in the figures for a couple of States, including California, the Department survey where there was a comparison of federally funded participants in March to Federal and State combined participants in September. Once that was corrected, the number being cut went up. Our best numbers at this point are 280,000 people coming off the program and 27 States between March and September with about 10 States being particularly hard hit. Among them California, as you know, and Missouri, which reports that 14,000 people are being removed from the program in Missouri by September.

What makes these figures even more unfortunate, I think, are two things. No. 1, as Congressman Durbin alluded to, I think there is a problem in calling the people who are being removed low priority. What this really means, for example, is that a pregnant woman might not be able to get on a program in a given state because she has not yet demonstrated medical and nutritional problems or a child has not yet become anemic, but the WIC Program is supposed to be preventive as well as remedial. Some of the States are in fact being forces to abandon the preventive aspect of the program now in order to get their caseloads down. That will cause greater problems later on.

Second, it comes at a time when, as you know, many eligible people are already underserved. I do want to comment on Ms. Nelsen's response earlier that according to the Department's figures about 90 percent of the eligible pregnant women and 100 percent of the eligible infants are being served.

The problem with those figures is that they were based on a study the department did about 4 years ago to estimate the number of eligibles for WIC in which they did the best that they could with the very crude data available. Because some States continue to have women and infants that can't serve, we have been puzzled by these data and several months ago began a major study of them. We are still in the midst of the study.

The conclusion we have come to is the Department's estimates, while the best they could do on the data they have, seriously underestimate the number of people eligible for WIC. I will give you one quick example. The Department's income data used people's annual income. When you go into the WIC Program, if you are poor and unemployed and you are eligible and 4 months later you get a job and go off the program at that point, your annual income is above the WIC income threshold, but you were eligible during that 4-month period.

These people won't be picked up by the Department's figures.

As to why this has occurred, I think Mr. Emerson has stated it precisely regarding the food crisis. We have a table in our testimony showing that milk prices are 11 percent higher than a year ago, cheese is 13 percent higher and fruit juice 14 percent higher.

The other point I would really like to make is—I am a little concerned about this—is that the hearing so far today has focused primarily on the food prices. We think there is a bigger problem, and

the problems coming in 1991 may be larger than the problems you face today. That is because what is happening in infant formula rebates.

Every State in the country has a cost containment program to reduce infant formula prices. We have a table that I think staff have, can make available to you showing that over the last 10 years formula prices have gone up 150 percent while milk prices have gone up 36 percent.

Milk is the principal ingredient of formula. In response to this these infant formula cost containment systems were implemented. At the beginning of 1990 the average state was getting a rebate of $1.25 a can for each can of formula sold through WIC. In Maros Laboratories, the largest formula manufacturer in the country, submitted a bid of only 75 cents rebate to Connecticut, well below what it ever was in years, a competitive system. It was not an attempt to win the bid. It sent a signal to other companies to get the rebates down.

Six days later Mead Johnson issued a letter to a number of States, an unusual letter saying an enclosed sealed bid system we are publicly announcing in advance we will bid 75 cents a can, exactly the level in the Ross letter. Wyeth has since followed suit. Rebate levels are tumbling in a number of States by as much as a third.

The rebate levels in many States are coming in at the same amount. Oklahoma is in the situation, it is the reason they are now cutting 28 percent of their people off the program. Ms. Nelsen said they were cheered this pattern didn't occur in Texas. I find the Texas developments very disturbing. We had thought at least this pattern wouldn't extend to States like Texas or California because they have such a large market that no company would want to give it up.

What happened in Texas is Ross Laboratories only bid 50 cents a can at a rebate. No one has ever won on that level. It was clearly an attempt to walk away and not compete and let Mead Johnson, that had the existing contract, get it renewed. We are concerned this is a divisions of markets arrangement.

Mrs. BOXER. I am going to ask you to conclude at this point.

Mr. GREENSTEIN. The conclusion is only a few States have had their cost containments come up for renewal. By the end of fiscal year 1991 over half of them do. If the pattern of recent months extends to those States, you are talking about cutbacks in 1991 that take the current situation and make it permanent.

We are talking about a potential permanent loss of $100 to $200 million in rebate savings and several hundred thousand people taken off the program.

I would just end by saying for all these reasons the bill introduced by Congressman Hall is very helpful and we support it. It is not a solution to the problem. The solution is what Congressman Hall initially called for, a supplemental appropriation and an adequate funding level next year. His bill will ease the current problem and to some degree now extend the problem somewhat, there is no other way around it, into 1991, States will be borrowing under his bill from the 1991 money to meet the current problem. You

should enact his bill, but it makes it even more important to have an adequate funding level for next year.

Between that and the rebates and continued high food prices, you will be having another problem like this next year and it will be worse.

[The prepared statement of Mr. Greenstein may be found at end of hearing.]

Mrs. BOXER. Thank you. Two of us did mention in our opening statements this formula problem. We are aware of it. I know Mr. Hall and Mr. Emerson, as they look at this program in the future, will begin to focus on these long-term problems. This hearing is one really dedicated to the immediate crisis. I really appreciate your raising it with us in such a forceful fashion.

Dr. Paige from Johns Hopkins University.

STATEMENT OF DAVID M. PAIGE, M.D., M.P.H., SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERISTY

Dr. PAIGE. Good morning Congresswoman Boxer and Members of the Task Force.

I am David M. Paige, professor of Maternal and Child Health at the Johns Hopkins University School of Hygiene and Public Health with a joint appointment in pediatrics at the Johns Hopkins Hospital. I am chairman of the Maryland State Advisory Council on Nutrition and a member of the State WIC Advisory Panel. I appreciate the opportunity of appearing before the Task Force this morning.

I would add parenthetically the Members of this Task Force are very well versed on the issues at WIC, impressively so as I listen to you this morning and invite any and all of you down to lecture to our public health students on the issue and value of preventive intervention.

I would like to reenforce and highlight several issues coupled with WIC. I will highlight some of the comments of the prepared testimony and some of the work that we have published or appended thereto and may be made part of the record if you so wish.

Clearly, you already know that maternal nutrition birth weight and infant survival are inexorably linked. This is an important consideration in low income, high risk women. Differential patterns continue to exist in pregnancy outcome between high and low socioeconomic groups. Approximately 7 percent of all U.S. births are low birth weights, with the incidence of LBW in poor white and black infants particularly high at 12.4 percent, and in advantaged white infants at 5.6 percent. In addition, almost 17 percent of black infants are premature, born before 37 weeks of gestation. In the absence of prenatal care the percentage of premature infants born to black women climbs to 31.2 percent, and for white women the figure is 22 percent.

I would emphasize at this point parenthetically that WIC in addition to its direct health impact, is a very important vehicle by which women receive prenatal care. The WIC impact on pregnancy has been looked at over the past decade. The evidence is clear that significant improvement in birth weight and a reduction in the number of low birth weights have been reported.

Data from the National WIC study, indicates that there is a large reduction in premature births, as well as infants of low birth weight born in premature births, as well as infants of low birth weight born to high-risk white and black women. The estimated reduction is 23 percent among white women and 15 percent among black women. There is also a corresponding increase in birth weight.

This outcome is consistent with the fact that women initially enrolled in the WIC Program reported consuming 100 to 140 calories more than control women. Further, women enrolled in the WIC Program also reported a significantly greater intake of 14 nutrients. Out of these five, four show an appreciably higher level within women participating in WIC compared to those controlled. Protein, iron, calcium, and Vitamin C being those nutrients.

The GAO report several years ago underscores these findings and indicates that the percentage of WIC mothers with low birth weight infants was 7.9 percent compared to 9.5 percent in non-WIC mothers. This decrease of approximately 1.6 percent will result in a 20 percent decrease in the projected number of LBW infants. The projected reduction will result in 49,620 fewer LBW infants being born, approximately 5,000 fewer LBW neonatal deaths, and an estimated savings of hundreds of millions of dollars. When I heard Ms. Nelsen indicate that the cost is $50 million per 100,000 enrollees, some quick calculations that I made in the back of the room indicate that for every 100,000 women in the WIC Program, there would be a reduction, 100,000 women would represent approximately 12,000 low birth weight newborns being born, a reduction of 20 percent of that figure would reduce the low birth weight population by 2,400 infants. If we take the lowest figure of the Institute of Medicine data, which indicates the cost is $20,000 for a low birth weight infant, those costs range up to $100,000. But taking the lowest figure, that equals $48 million saved; $20,000 per 2,400 less low birth weight infants. It also equals a reduction of 24 deaths for those 100,000 women.

So we are not talking about trivial issues here. The cost we are going to pay, and we need to decide whether we want to pay it on the preventive end of the spectrum or on the medical health end of the spectrum. I would submit the preventive end is better.

I won't go into the Medicaid cost analysis which indicates a reduction in health care costs for those participating in WIC. I have a brief review of that in my testimony.

I would mention with respect to the food package that too much distorting of the food package by eliminating essential foods for some of the population, particularly pregnant women, is an unwise move at this point particularly when the National Academy of Sciences' most recent report on weight gain for pregnant women urges a robust in weight gain for those women to levels of 45 pounds during the pregnancy.

This would not be a prudent way to affect cost saving.

I would like to note with respect to the preschool period, this is not a throwaway population. Although available information is incomplete, and I agree with Ms. Nelsen and applaud the activity of the WIC Child Impact Study which we at Hopkins are participating in, I would also urge you not to accept the notion that the pre-

school child be eliminated as a disposable element of the WIC Program.

This is a vitally important population. This is an important age of growth and development. This is an age of high levels of vulnerability. While we may not be able to detail specifics in growth, there is clear indication of change in cognitive development and performance.

Preschoolers are going though a period of very rapid growth and intellectual and social development. Poor nutritional status cannot only lead to changes in cognitive development, but to increased risk of disease.

I would also note one thing is not ambivalent or ambiguous with respect to this issue. That is that infants and early school age children are particularly at risk for iron deficiency anemia. This was noted in the original legislation in 1972. It continues to be a fact. We have had a sterling success in this regard in reducing the level of iron deficiency anemia in the United States as a result of this program.

The National WIC Evaluation reports that infants, and preschool children ingest 33 percent and 15 percent more iron respectively than control children. According to the Centers for Disease Control, WIC has contributed to the decrease in iron deficiency anemia among low-income preschoolers between 1975 and 1985.

It is important to note, that iron, along with other nutrient deficiencies, may also play a role in influencing intellectual development. Specifically, iron deficient infants have lower mental development scores that those with adequate iron. Iron deficiency can also be associated with deficits in attention and new-concept learning among preschool children, and with lower educational achievement test scores among school children.

I would note the iron deficiency anemia has a specific impact in terms of the cognitive and mental development of these children and that the need to address this is very important. The National WIC Evaluation did show clearly vocabulary scores and digit memory was also significantly reduced.

Mrs. BOXER. Dr. Paige, I hate to stop you because this is so important. It is in your testimony. I would ask if you would stop at this time. I would thank the whole panel.

[The prepared statement of Dr. Paige may be found at end of hearing.]

Mrs. BOXER. I don't have any questions.

I would ask Mr. Hall if he has questions at this time. Then I will go to Mr. Buechner.

Mr. HALL. Thank you, Madam Chairwoman.

Mr. Greenstein, you are absolutely right. The bill that I have introduced is a temporary measure. If I had my choice, I would like to have a supplemental appropriation, too. I don't think I would have my choice on that one. This is a two-step process.

First, to try to handle the emergency. Of course, No. 2 is to followup next year on the long-term solution. That is what we are really interested in. So, it is a two-step process. It is incumbent upon me and Members here and you—all of you here today—to help us look at the long-term approach.

It is very alarming what you say about the rebate program. You used the figure of $100 to $200 million in less money coming back for the rebates. So, you are saying that is $100 or $200 million less than they are already getting? That if the current trend continues—what a couple of the States have negotiated—we will lose $100 to $200 million next year. Am I correct?

Mr. GREENSTEIN. Let me clarify. When, if the current pattern that has held since the beginning of March extended to all states in the country, the loss and unfortunately at this point is is more likely that it will that that it will not, the ultimate loss would be $100 to $200 million which would probably translate into 200,000 to 400,000 fewer people on the program.

That is not a 1991 figure because not every State in the country renegotiates its current contract by 1991. More than half of the States in the country do renegotiate by the end of 1991.

We have not computed exactly what amount of that would be in 1991. I think it would be something less than $100 million, but still substantial. By 1992 or 1993 if the pattern held, the $100 to $200 million loss would result.

Let me also just quickly add that I and, I think, many others in this room are greatly appreciative of the leadership you have exhibited on these issues over the last number of months. In a comment I made at the end of my testimony I knew very well you understood this, I just want to make sure everyone else in the room understand neither you nor we saw your bill by itself as the total solution.

Mr. HALL. Yes, thank you. If, in fact, the current trend on rebates occurs, what action must we take to be prepared for this?

Mr. GREENSTEIN. I think there are a couple of aspects to this question. On May 29 the Senate Anti-Trust Committee held a hearing on this issue at which the Federal Trade Commission testified and expressed concern both with these patterns and with the general pricing patterns under which the three major companies raised prices pretty much in long step and pretty much to the same levels and announced that the FTC was launching an inquiry into the formula pricing practices.

Hopefully that might in time lead to some remedy. But given that FTC investigations take a long time and that any remedial, that may be ordered is likely to be challenged in court by the companies, I think there is not a likelihood that that would impact developments in 1991, maybe even not in 1992.

I think what that suggests since the Congress cannot pass legislation mandating companies to bid at certain levels, in fact, our complaint is precisely that the competitive system now isn't working the way it intended because it is signaling among all coming in at the same level, I think that suggests that the major thing the Federal Government can do at least while the FTC investigation is proceeding, is to provide adequate levels of appropriation.

You know, you have all said, we have all said today that no one could anticipate the rise in dairy prices or the freeze in the orange groves in December. But we can anticipate what is likely to happen next year with these rebate contracts. We need to take that into account when we write the fiscal year 1991 appropriations bill.

Mr. HALL. Mr. Bach, you sent me a letter and you said another option—we were talking about various ways to look at this emergency—another option is to increase, at least temporarily, the spend back authority within the current law. Under current law the States can borrow ahead up to 1 percent. You suggested the possibility of raising that 1 percent to 5 percent. There has been some talk about amending my bill to do that. What kind of money are we talking about? Do you have any estimates?

Mr. BACH. I don't have an exact figure, although I believe if you look at the list of States that are currently cutting caseloads and the number of dollars that they have estimated it would take to resolve that problem, the majority of these figures are within 5 or 6 percent of their current year's appropriation or grant level.

I think that if the 5 percent provision were enacted, there would be some States that would be able to take advantage of it. There would be some States that wouldn't. I would guess that probably the upper limit of that would be somewhere around the $60 million or so that is in the list that we provided. It would probably be somewhat less than that.

Mr. HALL. Do you have any idea of what percentage of further caseload reductions would occur as a result of changing that law from 1 to 5 percent? Do you have any kind of estimate?

Mr. BACH. I am afraid I don't at this point. I can come up with an estimate, though.

Mr. HALL. I would appreciate that. Mr. Greenstein.

Mr. GREENSTEIN. I have looked at both of the issues you have asked about. I think the upward limit under the 5 percent, and I would also add that we also think that is probably the best way to frame it with the 5 percent, the upward limit would probably be about $38 or $40 million. I really don't think it would be anything close to that amount.

One fortunate development is that milk prices are starting to come down. And I think for some of the States, if you allow the State to borrow 5 percent of the money, they may turn out to only need 3 percent. The problem is that States, for all the reasons Mrs. Nelsen stated, States can't hit a number on the nose in this program. If they have no authority for state funds, if you tell a State you have X amount of money, the State will end up spending often 1 or 2 percent less than that because they have to.

If they have over the top, there is no money to pay for it. So raising it to 5 percent will, allow States to plan on that amount. Many of them won't need quite that much. What will it do to the caseload cuts? It will certainly reduce the caseload cuts by more than half. How much more, I don't have a precise figure. It should reduce them by more than half. We looked at the 25, 26 States as of the time last week we had this information.

It is not the 27. The 25 we had last week, I looked at the 5 percent figure. It looked to me about two-thirds of them it should fully cover the problems they have and should cover the majority of the problem in all but one or two of the remaining states.

Mr. HALL. Thank you.

Mrs. BOXER. Thank you, very much. Mr. Buechner.

Mr. BUECHNER. Dr. Paige, on page 3 of your prepared text, you refer to the Missouri study. Are you also aware, though, that Mis-

souri back in the late 1970's instituted a prenatal program that, I think, at that time was one of the most unique in the nation? I am proud of that because I handled it for the Governor in the legislature. What impact does that program have in addition to the WIC Program?

Dr. PAIGE. You have every right to take pride in that program. Each complements the other. There is a synergy that exists between all of these programs. To try to disaggregate each one is a disservice to the other. WIC is a critical element in both reenforcing the nutritional state, particularly the poorest, and particularly in getting many of our pregnant women and young children in for prenatal services as well as immunization.

They are both important. Particularly now as we go to presumative Medicaid eligibility, we are trying an experiment in the State of Maryland and I am sure elsewhere to try to integrate WIC and Medicaid so that there is a one approach to the health services, the Medicaid eligibility is determined on the spot. So, too, is the WIC service. And women are enrolled in both programs.

Mr. BUECHNER. When you say Maryland is trying to integrate the programs, are there any guidelines for you to do that? Are you going to have to bootstrap that yourselves? Are there any other States which serve as models for you?

Dr. PAIGE. We appear to be be bootstrapping that a bit currently in Maryland, There are others that are looking at it. I don't know the model program on the national scene. There may be others that are more advanced.

In Maryland we have been looking at what Mr. Greenstein indicated. That is the cut back in our rebates in 1993. We anticipate a rather sharp reduction in the number of individuals.

We are trying to convince at this time our State folks to come in with supplemental budgets.

Mr. BUECHNER. Mr. Greenstein, you heard Ms. Nelsen talk about the problem of just increasing the amount of money in the program because of disparity between the various States. Have you gotten any suggestions on how to resolve that disparity? I mean is uniform eligibility standards the way to go? How should we be going?

Mr. GREENSTEIN. With regard to the uniform eligibility standards, there really is much more uniformity than I think you may have gotten the impression from earlier in the hearing. States do have the flexibility to set the income standards at different levels. All but three States use the same income level.

Mr. BUECHNER. What are those three States?

Mr. GREENSTEIN. I don't know off hand. I can supply it for the record.

Mr. BUECHNER. You sound like a Congressman now.

Mr. GREENSTEIN. We have it back in the office. I know we recently looked at that and found all but three States were at the same income variable. That is really not the issue, I don't think. She correctly stated the fact that there are variations in the proportion of eligible participants that various States are now reaching.

There is a national funding formula that is designed to bring States closer together over time in the proportion of eligibles that

are served. That formula uses the same criteria for all States even if States vary a little bit in their own actual practice.

So there is really apples and oranges here. There isn't the problem that is posed for the funding formula by the current eligibility standards we have. I think the point she was simply trying to make was that if you did a supplemental appropriation that got enough money to the States that are now cutting and using the current formula, you have to have several times as much in the appropriation, as just those individual States need it.

She said if you put a certain formula in the level of appropriation to deliver to the States in trouble, that might be inequitable to States because they have not been using their allocation. There are States not cutting. There were States not using their full allocation earlier in the year.

Instead of using additional money for expansion, they just used it to say where they were. Given it appears there is not going to be a supplemental appropriation this year anyway, I think the issue is moot. I do think we do have, the department does have a good, fair funding formula for allocating the money among the States, and I think it should be retained.

Mr. BUECHNER. Thank you.

Mrs. BOXER. Thank you, very much, Mr. Buechner. Mr. Wise.

Mr. WISE. Thank you, very much.

I want to try to get the budget figures again. I know it is hard. It seems to me the story coming out of this tat, for today is that you think you got problems now in this hearing. Wait until fiscal year 1991 is in effect and several things happen, several things happening be rebates drop for the number of states you are talking about.

I think Mr. Greenstein you said roughly $100 million in fiscal year 1991. Milk prices may be dropping, but I don't think the inflation is going to drop. I don't think you are going to see significant drops. It looks to me like we are going to be at least $200 to $250 million down below current services. With $150 million that the budget can assume, we hope to be up serving more people next year.

Not only are we not serving more people next year, but we are likely to see further cuts. Is that a fair assumption?

Mr. GREENSTEIN. Let me, if I might, also ask Mr. Bach to help answer this. I believe that the association has done an estimate of when you look at the impact into next year of the higher food prices that are with us that under a conservative estimate the association has, and I have looked at their numbers and they look good to me, they have estimated that about $42 million—the true current services just because of higher food costs would eat up $42 million more than the CBO estimate done back in January or February.

As you know, when CBO does a current service estimate, they use one inflation adjustment for the entire Federal Government. They don't use an inflation adjustment just for WIC foods. You have got about $42 million there. Now the rebates, it is something up to $100 million.

I don't know whether the best estimate would be $50 or $80 million. I have not really refined it. But what that tells you is that it is likely that the majority of the $150 million over current services

as assumed in the House budget would really be needed just to keep us at a standstill level.

Mr. WISE. How much was that?

Mr. GREENSTEIN. Well over half of the $150 million. Whether it is $90 million or $120 million, I don't have an exact figure. But well over half would be needed just to keep us where we are now. What particularly concerns me, you know, is as much as I like everyone else applaud yesterday's developments and the real need to get an agreement to bring the deficit down, I hope that does not result in such low domestic discretionary numbers that the Appropriations Committee finds that they have to not only not go above the $150 million, but remove the $150 million.

I am worried about a combination of a current services are modestly over level because of squeezed domestic discretionary money, combined food prices and a rebate fall. You put all those three together, that is a frightening picture.

Mr. WISE. I hear over 2,000 kids in West Virginia aren't getting back on WIC next year. Indeed there may be more coming off.

Dr. Paige, I have had a heck of a time. I am trying to compare. I have got a feeling that the UN recommends at least the same level, if not more, for hungry children anywhere in the world than some of the cutbacks we are going to have in WIC packages. For instance, I get concerned when I see one State going from 36 ounces of dry cereal a month to 24. That is way less than an ounce. A 9 month old isn't going to make it on that.

Have there been any studies comparing the WIC package to what it is that Care or World Hunger or other organizations? We tried to get some figures, for instance, what the recommended level is for those being held in the Hong Kong refugee camps and to try to do a comparison. Have there been any comparisons? If not, would it be possible to do one?

Dr. PAIGE. Very interesting question. Actually we have not done that. I would comment that the nature of the food package varies with the age specific, on an age specific basis. For pregnant women generally the food package might provide 900, 950 calories and is particularly sensitive to additional cutback in the food package for pregnant women. With a 1 year old, however, the current food package is quite liberal with respect if one were to not tailor the package at all, it would actually not only meet but exceed, as an example in protein, the overall requirements, so the question is a very important one.

It has to be analyzed on a population specific basis and then on a nutrient specific basis. You have the paradox of having low iron in the food package for 1 through 4 year olds, particularly the 1 to 2 year olds where you are trying to address the issue of iron deficiency anemia. The package is very high the first year given the iron fortification of the formula.

Beyond that it is quite low. You need a nutrient specific analysis, a calorie specific and an age specific. I would be happy to try to develop some comparisons and send them to you.

Mr. WISE. Thank you very much. I yield back my time.

[At the time of printing the information referred to above had not been submitted.]

Mrs. BOXER. Thank you, Mr. Wise for yielding, because I want to give Mr. Emerson a chance to close the questioning of this panel. Then we will reconvene.

Mr. EMERSON. I don't have any questions. I just want to thank the very credible panel for their very valuable expert and objective testimony.

I think you have given us factual data on which we can and should act. I think that WIC is one element of the social safety net, as it were, that pays the greatest dividends. It is an up front investment that has very long-term consequences, and it deserves our highest level of attention, understanding and action.

Dr. Paige, I was interested in your comment about integrating WIC and Medicaid. I think there are probably a lot of other elements in the social safety net that ought to be integrated in order to better address the needs of disadvantaged people. I have long been an advocate of a concept that I call one-stop shopping. We ought to be able to go one place and get the help we need rather than chase around from agency to agency and agency and bureaucracy to bureaucracy to bureaucracy.

I am interested in your concept. If you are trying to get WIC and Medicaid integrated, you are making a step in the right direction.

I thank all three of you.

Mrs. BOXER. Thank you, very much, Mr. Emerson.

I want to really thank the panel for adding another dimension to this discussion. I think it is important and interesting to see the bipartisan support for this program. I think it is also important to see what happened in the budget this year when we did have a $500 million increase for Head Start. Now you can't support, it seems to me, a $500 million increase for Head Start, have new kids enter, but the kids entering are unhealthy. These kids are not going to make it in Head Start. They have to at least have that very early start and then get into Head Start and into a continuum of help for very high at risk children.

I want to thank the panel very much for alerting us to the formula problem, for telling us how important the issue is. We will indeed use your oral testimony and your written testimony to help us in the fight to save and to indeed expand the WIC program. We thank you very much.

What we will do now is take a brief recess, probably about 10 minutes, come back and hear from the final panel.

[After recess.]

Mr. HALL [presiding]. We have Denise Ferris, the WIC Program director for the State of West Virginia; we have Linda Barr Gale, director of the Bureau of Nutrition for the State of New York; Debra Stabeno, the WIC director for the State of Texas; and Carol Trent Walker, who is a WIC recipient and member of the board of the Maryland Food Committee.

I understand Ms. True has not arrived yet. I would like to start with Dr. Ferris and go right down the list. Please summarize your comments and your written statements will be made a part of the record.

STATEMENT OF DENISE V. FERRIS, R.D., D.P.H., WIC PROGRAM DIRECTOR, STATE OF WEST VIRGINIA

Ms. FERRIS. Thank you for the opportunity to appear before you today. My name is Denise Ferris, director of the West Virginia WIC Program, and I would like to speak to the problems facing this program in my State.

The WIC Program in West Virginia served 30,519 in 1988, and 30,868 in 1989 with Federal funds. West Virginia started to build caseload early in fiscal year 1990 in anticipation of additional dollars generated by infant formula rebate. We began conservatively, continuing the policy started in 1989 of serving only Priorities I, II, and III.

However, we soon realize that we would not be able to serve all of our Priority IIIs even with the average caseload of 34,620 in fiscal year 1990, and continued the policy of not serving Priority IV, V, or VI.

As food prices continued to rise through the late fall and into early spring, we considered the options to either reduce caseload or to reduce the food package. Throughout the discussion, the State nutrition staff was opposed to decreasing or limiting the food package, since the WIC Program would lose its effectiveness if the food prescribed is not actually consumed.

Peanut butter and beans have always been limited to certain risk codes. The eligible food list was revised in April 1990 which included some cost-saving measures. The final decision, to decrease caseload through a reduction of Priority IIIs, was made with regret.

Along with caseload reductions comes negative publicity. Our no-show rate for current participants increased and our potential participants are reluctant to apply, assuming they will not get on. This has far-reaching effects. With less family members on the program, I believe the food package is being diluted by increased sharing of food in families.

This limits benefits of the food package, and I am afraid we will see an erosion in the gains made in improved pregnancy outcome.

Our waiting lists are filled with unserved Priority III's. We find it is a futile effort to even try to keep a list of the lower priorities.

Earlier in this fiscal year we estimated there were 3,300 Priority III participants on waiting lists in West Virginia. This is a conservative estimate. They only remain on this list for 60 days until their medical data expires. There exists a great unmet need even within the priorities we are serving. Approximately 40 percent of all births in West Virginia were to women on Medicaid and other State-funded prenatal care programs.

I feel we have a long way to go toward our goal of reaching all Priority I's.

As much as it is discouraged, the WIC Program is often looked upon as an emergency food source. I had a conversation with a mother knowingly writing bad checks in order to get formula for her baby. There was no other safety net for her infant.

I fear this is true for many other infants in West Virginia. I would like to share with you some of the situations of our local WIC clinics and WIC participants.

Pregnant women and mothers of infants call the WIC clinics and want to cancel their certification appointments or be taken off the active roles so the children can have their slots. These Priority I's and Priority II's have to be convinced to keep their appointments and stay on the WIC programs.

Private citizens have called in the State office to ask how they can help. In some clinics a Priority III child must have a risk score of 30 points in order to be certified. This is too high to serve 3 or 4 year olds who are underweight or anemic.

It is not unusual for families to have two or three children on the Priority III waiting list.

The integrity of the prescribed food package is compromised in case studies such as a pregnant woman on WIC shares the food with her 2 year old not on WIC and her diet continues to be inadequate. A WIC family waters down concentrated juice to stretch it to feed a 1 year old on WIC and a 2½ year old not on WIC.

We are not optimistic about the growth of the WIC Program in West Virginia for the next fiscal year.

Our public bid opening for our next contract is June 28, 1990. If the 75 cent bid is accepted, it is projected that this will result in a reduction of approximately 2,000 participants per month in West Virginia.

You already are apprised of the current situation where the West Virginia legislature is trying to assist us with our shortfall, but I feel this is only a short-term solution.

Mr. HALL. We are having trouble with that microphone or you are not speaking into it. I am not sure.

Ms. FERRIS. That is it. Thank you.

[The prepared statement of Ms. Ferris may be found at end of hearing.]

STATEMENT OF LINDA BARR GALE, DIRECTOR, BUREAU OF NUTRITION, N.Y. STATE DEPARTMENT OF HEALTH

Ms. GALE. Thank you for this opportunity to speak today about the important funding problems now facing the WIC Program. I am Linda Barr Gale, director of the New York State Department of Health's Bureau of Nutrition.

As both a nutritionist and a health administrator who has had responsibility for managing WIC programs for the past 16 years, I have been involved with and gained perspective on the evolution and dynamics of the WIC Program.

Declining WIC participation in New York State has been a concern since 1984 when a new Federal funding formula was used to channel growth funds into States falling below the national average WIC caseload. These States were called "equity" States by USDA.

Nonequity States, like New York, serving a higher percent of caseload than the national average were expected to have their caseload stabilized through adequate yearly inflationary increases added to the prior year's base grant. But New York State's WIC caseload actually dropped during this period.

In response, we began a major cost containment initiative in 1986. We pared down our food package items, designed a sophisti-

cated new WIC banking system, placed payment restrictions on retailers for WIC foods, and implemented aggressive legal action against any WIC retailers overcharging the program which included an agreement with the Food Stamp Program to prevent violating stores from participating in the Food Stamp Program.

Through these initiatives New York directly and significantly lowered food package costs and began serving an additional 70,000 people per month. In 1989, New York implemented an infant formula rebate system allowing another 50,000 clients per month to be served.

We lowered our costs by 27 percent. This was one of the largest and most successful cost containment efforts nationally, and allowed us to increase our caseload by some 120,000 people. But our success in cost containment has, in fact, masked the yearly decline in Federal support as a consequence of inflation.

For example, in fiscal year 1988 Federal WIC funds supported 261,191 New York WIC clients; our actual inflation rate was 6.3 percent but we received only 3.9 percent for inflation from USDA. Similarly in fiscal year 1989 our actual inflation rate was again 6.3 percent but we received only 4.4 percent from USDA to "stabilize" our caseload. Subsequently, if we strip away the effect of the infant formula rebate, our fiscal year 1989 caseload supported by Federal WIC dollars dropped by 3,000 people to an average of 258,256.

If we look from 1988, when New York State's actual inflation was 6.3 percent and our inflation grant was 3.9 percent, it is no wonder that our average caseload dropped. In the next fiscal year, although we subsequently received funds to only service 258,000 people from our federally supported grant, we were actually able to increase our caseload on average by another 53,923 people to average 312,000 caseload solely due to the infant formula rebate.

This masked the fact that we actually dropped in our Federal support. The increase that we saw during that Federal fiscal year was indeed due to the infant formula rebate, not an increase to cover or stabilize our caseload.

In 1990, the situation has worsened much, much more because we received only 4.09 percent for inflation. For the first 6 months in New York State the inflation has actually averaged 9.1 percent.

This has meant that our federally supported caseload has dropped to 248,000 on average and that if it wasn't for our infant formula rebate serving about 81,000 clients per year, our overall caseload would have dropped again precipitously.

Instead, the infant formula rebate masked the fact that our Federal support did drop. I picked up a USDA factsheet on the table over here, looking at what USDA says is a situation in New York State. They, indeed, do talk about our fiscal year 1989 WIC caseload being 312,000. They then point out that our March caseload was 316,000 and that our average to date is 331,000.

What they are not saying is very important. In New York State, because we are State supplemented, we can allocate our Federal grant into one-twelfth caseload management units, meaning that each month we spend one-twelfth of our Federal grant.

In October 1989, the first month of fiscal year 1990, we were able to serve with our Federal funds and rebate revenue, 341,000 New Yorkers. That has dropped every month so that by this April we,

with the same one-twelfth of our Federal appropriation and rebate have only been able to serve 309,000 New Yorkers due to inflation.

That is over a 30,000 drop since October. If inflation continues at this rate through September 1990, we can expect our one-twelfth of our Federal grant plus our rebate to cover only 286,000 New Yorkers. That will be a drop of 55,000 people.

We do however, anticipate a slackening off of inflation. We estimate that it will go down to about 4 percent during the second 6 months of this fiscal year. What that means is that we now anticipate New York State will go from a caseload in October of 341,000 to a caseload of 296,000 New Yorkers.

This is not a caseload management issue as USDA implies. Since we use our Federal allotment in one-twelfth increments it is clear how detrimental inflation can effect caseload. We are not stacking the deck by using more Federal funds at the beginning of the year only to run out of funds at the end of the year as implied in USDA's testimony. This is not the case. In New York you can clearly see the significant impact of inflation. When you have a caseload dropping like this, it clearly shows that the WIC Program is in trouble.

The $235 million increase that has been projected for expanding the WIC Program, in our estimate, is not enough. When we look at what needs to take place, looking from a New York standpoint and then extrapolating nationally, it is clear that something needs to be done now about the 1990 base grant.

The 1990 base grant has not stabilized the States that it was supposed to stabilize.

What is happening to us is happening to other States across the nation. And in order to safeguard our current level of service, you must first adjust the 1990 base grant so that it truly reflects a stabilized level.

On to that you then must add, not what CBO is projecting which is another 4 to 4.2 percent increase, but an inflation rate that is based on WIC foods, that are sensitive to the fact that milk is going up, for example, in our State by 12 percent.

There are some regional differences, but every region was hurt across the United States. We were particularly hurt in the northeast.

In order to stabilize the level for 1990, what would be needed for New York State would be an increase of another $5 million. What would be needed nationally would be $53 million.

To stabilize for 1991, we do not believe the 4.2 percent is going to make it. We think something more along the line of 7.1 percent is closer to what would be necessary based on a 4-year inflationary average for WIC foods.

This would require another $139 million to add to the adjusted 1990 base grant level. When you put the two together in order to stabilize the 1990 current service levels, you are going to need about $191 million out of the $235 million potentially allocated to WIC.

Mrs. BOXER. I would ask that you complete your remarks, please.

Ms. GALE. Our current rebate is $1.50 a can. We generate $42 million with that rebate. If, in fact, we are reduced when we go out

for bid in 1992 to 75 cents a can, we will have to reduce our caseload by 40,000 individuals.

We are currently working with the New England States to come up with a regional proposal to not only try and safeguard New York's interest, but also try to help the other States in the New England region as well.

[The prepared statement of Ms. Gale may be found at end of hearing.]

Mrs. BOXER. Thank you very much, Ms. Gale. Our next witness is Debra Stabeno, WIC director, State of Texas.

STATEMENT OF DEBRA STABENO, WIC DIRECTOR, STATE OF TEXAS

Ms. STABENO. I am honored to be asked to testify before your task force. You have heard a lot about the Texas program today, so I am just going to mention a couple of things that maybe you have not heard.

The first thing I would like to tell you is we were one of the States that came into the fiscal year expending our money from all sources. We have a State appropriation, we have infant formula rebate money and our Federal grant.

Basically we had planned fiscal year 1990 in the State of Texas as a no-growth maintenance mode year. That is why we have been caught when the 4.5 percent inflation we had budgeted for in food increases went to 9.8 percent in the first 4 months.

What I wanted to share with you is we as managers have to make decisions very early in this game. We can't wait for notice of availability of funds like USDA announced yesterday as reallocation money.

That is 9 months after the close of that fiscal year with only 3 months left to spend it. I want to share with you that at least the State of Texas, and I presume my colleagues in other States, have anticipated unspent 1989 moneys all along. We have budgeted for that all along. The moneys announced yesterday will not alleviate the problem in Texas one bit, and I doubt that it will alleviate it in other States as well. So, I share that for your information.

You have heard our numbers and inflation increases. You have heard we have taken drastic action to get back within our available funds. I would like to say to you that we, like New York, for years have modified our food package and made a lot of tough choices to stay within and stretch our budget to serve more.

We have limited peanut butter for years. We don't allow grape juice, infant juice. These are all things that have been in place for years in Texas.

In addition, what we have done this year is that we have moved to a less expensive brand policy for the majority of our items: evaporated milk, cheese, juice, peanut butter. We initiated the least expensive brand concept for fresh milk in 1988.

We have reduced our packages further for post-partum women and children. We have made reductions before. These are further reductions.

I guess I need to clarify that for young children, our reductions are more than reducing cereal. We have reduced juice, the milk package and we have reduced eggs.

So, it is severe. We have developed a plan to directly distribute to some of our WIC infants some sample formula that is available to us under our current contract with Mead Johnson.

So, we are doing everything possible to serve as many people and stretch the dollar to serve as many as possible. We have made a decision to temporarily eliminate cheese for 4 months, as has been done in California and replace it with fresh milk.

While we have been investigating the possibilities of rebates on cereals in the WIC Program in Texas, we have reduced the available brands down to seven out of a possible 40-some odd, which represent the least expensive in the major grain categories.

In addition to these changes, we have seen a tremendous increase in demand for our services in Texas. We initiated our first caseload policies in January in Texas. We strengthened them March 1. As of April 16, we have removed the preventive aspect of the program in our State and no longer serve the lower priorities.

I guess you have heard a lot of those concerns this morning already, and I won't go into that again. I want to share with you that this even impacts the high priorities being served in the State of Texas.

The length of our waiting lists and the demand for existing appointments, sometimes one or two months, is a barrier even for those high priority participants. So we are fearful that not only are we losing them for WIC, we are losing them for other critical public health services.

We are not getting them into prenatal care, getting the kids immunized, and we are not getting them into family planning services. I share that with you to think about.

We have talked a lot this morning about equity. Everybody has a different definition of equity.

But I say to you that I want to share with you another way to look at it. We in Texas with the cuts we have imposed will only be reaching 25 percent of our potential eligibles in another month.

That means three out of every four people that come to us, we have to turn away for lack of funds to serve them. The Texas WIC program is serving only 40,000 pregnant women up to 185 percent of poverty. The Texas Medicaid Program is serving 62,000 pregnanr women up to 133 percent of poverty. We have a long way to go to serve even the high priority population.

When we talk about equity, I share that with you.

Mrs. BOXER. Make your final comments. We would appreciate it.

Ms. STABENO. I want to share with you, we have made food package reductions based on the latest published recommended daily allowances (RAD's). Those recommended daily allowances are developed for the average healthy American public. Our WIC participants are not average, they are not healthy but they are American.

I just share with you that you can meet the RDA's and they can still be hungry or have an inadequate diet.

We have estimated in Texas what it will take to restore our October 1989 levels and restore cheese to the food package and

needed increases for 1 and 2 year old children. We have estimated we will need another $17.2 million in food funds next year.

Both the House budget proposal and NAWD's proposal fall short of that if we get the same share we have gotten in previous years. If we were able to serve only 30 percent of our population, it would take an additional 36.8 million in food funds this year.

I applaud you for holding this hearing. I encourage you to support an aggressive move toward full equitable funding for the WIC Program in this country. Thank you.

[The prepared statement of Ms. Stabeno may be found at end of hearing.]

Mrs. BOXER. Thank you so much for your excellent testimony.

At this time I call on Laurie True, food policy specialist from the California Rural Legal Assistance Foundation, an excellent organization that I have supported for many years.

STATEMENT OF LAURIE TRUE, FOOD POLICY SPECIALIST, CALIFORNIA RURAL LEGAL ASSISTANCE FOUNDATION

Ms. TRUE. Thank you.

I thought I would share a slightly different perspective from an advocacy point of view.

California Rural Legal Assistance Foundation has always been an advocate for the WIC Program ever since it began in the State of California on behalf of clients and local agency providers and the State when possible.

I could have told a happier WIC story about California just a few months ago. In California we only heard about the crisis on April 18. Before that, we were basically celebrating a tremendous caseload expansion over the last 18 months.

Since January 1989 rebate started, we have been able to add 110,000 participants with the highest rebate per can in the country.

However, our celebration was short lived. We are in a crisis and we are slated to cut 11 percent of the caseload by October 1 unless something happens here and possibly in the State legislature.

This is a very tragic step backward for WIC and very discouraging for advocates who have been through some very stagnant years.

I just wanted to go over some of the impacts at the local level from the client perspective of these cuts. The State of California is doing three things. They are cutting caseload drastically.

The most drastic cuts in the nation, I understand. They are cutting 53,000 participants, or plan to; 26,000 participants will be cut by eliminating, terminating or whatever you want to call it, cutting Priorities IV, V and VI; 22,000 additional participants must be cut because they were overenrolled in the first place.

Mrs. BOXER. How many additional participants will be cut?

Ms. TRUE. 22,000. Then approximately 5,000 additional participants will be cut by freezing enrollments to the highest priorities, Priorities I, II, and III.

Many local agencies, especially those who have been over caseload for the last 6 to 7 months have been told they must freeze enrollments to Priorities I, II, and III to their March 1990 levels.

We consider this very controversial and basically unacceptable despite the fiscal constraints. It is unacceptable to turn away high risk clients who are medically at risk and often pregnant.

The third thing they are going to do is—the second thing they are going to do is tailor the food vouchers. I have not been able to find out what other States are doing. But in California they are pulling all the cheese from the vouchers except in five very high-risk pregnant cases.

The situation is very complex because there are two sets of vouchers now in circulation, the old vouchers and the new vouchers. Most of them seem to be the old vouchers.

When you tailor the cheese out of those old vouchers, you are not substituting enough milk to make up for the milk requirement in the regulatory, you know, package.

This is a very serious concern to us. However, in the fact of impossibility of getting a complete bailout from the State general fund, California is into a severe deficit, it was considered the least of evils to tailor the packages until October.

However, if it does not end in October, we will be extremely concerned. California has dubious distinctions, cutting more participants, most drastic tailoring to the food package.

As far as I know, we are the only State that has taken the measure of freezing enrollments to Priorities I and II. We have been always very underenrolled. We are only serving 36 percent of the need.

We do not have any State funding because the current administration vetoed four or five attempts to do that. We are in dire straights. We are highly targetting to the higher priorities.

Basically, what is happening to these cuts is children in the WIC Program will be eliminated entirely. There wouldn't be children left in the program if this trend continues.

There has been an unprecedented demand for the program. Even in the first months of our fiscal year we were overenrolled as a State. That has only come down in the last 2 months. By 102 to 104 percent, we were overenrolled. It is only dropping recently.

It is not because of poor management. A lot of these directors are old pros. They know how to cut caseloads and they used their old tricks. But that has not worked.

For instance, in San Diego there is a waiting list of 1,000 high risk infants on the program. Orange County set up a formula donation campaign at the local food bank to take care of infants who can't get on the program.

I would like to emphasize that the food benefit reductions are a serious concern from a nutritional standpoint and as a public health nutritionist, I don't think it is acceptable even if it had been, you know, blessed by USDA to make these kinds of changes in the food packages, the new RDAs are not necessarily applicable to a high risk, low income population as Debra pointed out.

This must not be allowed to continue. It is a very serious first step that could be a slippery slope.

Basically, we need immediate fiscal relief. If we don't get fiscal relief in the form of a supplemental appropriation by the next few weeks, it will be too late.

Our cuts are already being implemented. We can't reverse ourselves. There has been enough confusion and miscommunication in the State of California.

We are on the track. If we don't get help, we will continue to drop. The funds for fiscal year 1991 must be increased. We have to scrutinize the food package and tailor it carefully.

Mrs. BOXER. Thank you very much, Ms. True.

Now, we will hear from Carol Trent Walker, a member of the Board, Maryland Food Committee.

STATEMENT OF CAROL TRENT WALKER, WIC RECIPIENT, AND MEMBER OF THE BOARD, MARYLAND FOOD COMMITTEE

Ms. WALKER. Thank you. I first became aware of the program of WIC 4 years ago purely by accident. I was pregnant with my son, Dan III, and happened to see a public service announcement about the WIC Program. Figuring nothing ventured, nothing gained, I called the number that was given at the end.

My husband and I were both working at that time, and the caseworker told me I was not eligible for WIC due to our combined income level but to call back if anything happened.

My son was born in December 1986. Two months later, in February of 1987, I was laid off. My unemployment and severance pay ran out, things were tight, so I called the WIC office again. The caseworker explained that WIC has two eligibility requirements, income level and health.

Since we were living off my husband's bring-home income of $180 a week, we fell under the guidelines for income, so Dan III and I went in for a health check. Dan was underweight and had a low iron level. I received vouchers for him for cereals and juice, and since I was breast-feeding, I received vouchers for milk, cheese, eggs, cereal, peanut butter and juice for myself.

When Dan turned a year old, I stopped receiving vouchers. Dan will continue to receive them until he is 5.

Every 6 months we go in for re-certification. At this time our income level is checked, via pay stubs, and our residency is verified by a utility bill, our health is also checked. We are also given advice on ways to improve our health and nutrition.

The WIC Program has allowed us to stretch our food dollars. There were time when the only food in the house was what we received from WIC.

The program helps thousands of families similar to ours, young families trying to improve their lives. In addition to the 60 hours a week my husband works, he attends college four nights a week, and I am also attending college. My goal is to open a day care center when we are able to purchase a home.

I only have two concerns about the WIC Program. I would like to see a program implemented, and greater emphasis placed on pregnant women and breastfeeding. My second, and main, concern is for families who are struggling to survive on one income. I know of a family of two, a woman and her infant son, who were receiving food from the program. When the mother, who has to work and, therefore, has to pay for day care for her son, received a minute pay raise, her son was cut from the WIC roles.

I feel that the program needs additional funding to provide for these families.

I would like to add two questions that Ms. Nelsen brought to my mind. If WIC is not in dire straits, then what about the funding for families who are ineligible for food stamps?

They are the working poor. They can't get the food stamps, but they are still nutritionally at risk. We need to help these families.

Also, if we are cutting the children from the WIC programs, what about these children who are already learning disabled? Don't they need to continue with adequate nutrition?

Thank you for your attention and support.

[The prepared statement of Ms. Walker may be found at end of hearing.]

Mrs. BOXER. I appreciate your testimony. It is very important to this Task Force.

I have a question for my California witness, Ms. True. Did you say as of this moment the new people going on the program are Priority I and II only?

Ms. TRUE. I, II, and III in some agencies. Many agencies have not been able to serve beyond Priority IIIA for years.

Mrs. BOXER. Okay. At this point, no one in Priorities IV, V, VI or VII are being added to the WIC Program in California, to your knowledge?

Ms. TRUE. No, no IV's, V's, VI's and VII's are being added.

Mrs. BOXER. I want to point out to my colleague, Mr. Wise, and for the record, that those in Priority IV, V, VI and VII—and we do have a way of dehumanizing these things—these are people who are not getting onto the program and getting terminated.

Pregnant and nursing mothers with inadequate diets, that is IV; V, children with inadequate diets; VI, post-partum, that is non-nursing, women at nutritional risk; and VII, participants who might regress in nutritional status without continued assistance, which was Mr. Durbin's point earlier. That what we are doing is abandoning people who are going to obviously become priorities I or II or III.

I think the point you make is really critical here. We can't discuss this strictly in numerical terms. We have to understand what we are doing.

We, if we do not act, are going to cause children to be hungry and to be deprived nutritionally. We have to just say it right out.

That is exactly what this is. We are going to cause children to be hungry and starved nutritionally in the United States of American in 1990. I just think it is a shame on our country.

It is an absolute shame on our country. It is time that we redefine what patriotism is because you cannot, it seems to me, love your country and love everything about your country, if you turn a deaf ear to hungry children.

So, I want to thank you all for your testimony.

Before I give the time over to Mr. Wise, I have one more question to ask Ms. Ferris, Ms. Gale, and Ms. Stabeno. That is, if you could just give me a yes or no to these two questions.

Is the WIC program in a crisis? That is the first question. Could you answer that? One word?

Ms. GALE. Yes.

Ms. FERRIS. Yes.

Mrs. BOXER. Can the States solve the crisis alone?

Ms. FERRIS. No.

Ms. STABENO. No.

Ms. GALE. New York State, I know this is not just a "no," but in New York State, our legislators and Governor have given us an additional $42.3 million to help support the WIC Program, and our caseload is still going down. They didn't give us this money to supplant Federal funds. They gave it for us to grow.

Mrs. BOXER. Let the record show then that the three directors from the State of West Virginia, the State of New York, and the State of Texas, and I would have to say it is pretty representative group, agree that the program is in a crisis and the States can't resolve it themselves.

And I think that is the purpose of this hearing, is to get to the bottom of the problem here and to know where we have to go. And I think that this panel and the others have clearly led us in this direction, that we need to do something.

I know that Mr. Hall went off to a hearing right now where they may be marking up his bill, which is a quick fix solution.

I can only hope that the fact that we have this hearing, which, again, was requested by my dear friend and colleague from West Virginia, the fact that we had these intelligent witnesses here today including a recipient, has helped push Mr. Hall's bill forward and will help get it through.

I want to make one more point.

The National Right to Life Committee has sent a letter urging that this program be granted a big expansion. This is the first time I know that that has occurred.

I have suggested to Mr. Hall that he circulate this letter to the people who are anti-choice in this House, who are the loudest voices against choice, and that they understand something that I certainly believe is true. You can't fight for the right for someone to be born and then tell them they are on their own.

Mr. Wise, if you would please, I would ask you to close the hearing, if you will.

Mr. WISE. I will be glad to.

I want to thank the panel. I have several questions.

Dr. Ferris, I apologize for not being here when you testified. I was actually out in the hall conferring about whether or not this bill might move in Education and Labor today and possibly get it to the floor in the immediate future.

I want to thank you very much for the help you have given my staff in preparing for this and the statistics. I also want to thank you for what WIC personnel are trying to do in our State. I met the group that I was with on Monday. They were very compassionate. They don't like what they are doing. They are searching for every way to avoid it. But the numbers are the numbers regrettably.

I would like to ask a couple of quick questions to all of you involved in the WIC Program. Statistics have been given by FNS that 60 percent of all eligible people being served in this country, and yet I don't think I have heard that from anyone sitting at this table.

Dr. Ferris, what is the figure in West Virginia?

Ms. FERRIS. We are estimating about 30 percent.

Mr. WISE. Ms. Gale?

Ms. GALE. We estimate with the change in the WIC and Medicaid income standards that there are 832,000 WIC eligible women, infants and children in New York State. We are currently only supporting with our Federal and rebate dollars about 309,000 people.

Mr. WISE. That would be a little over a third, but not below 40 percent, I think.

Ms. STABENO. We estimate after cuts have taken place, 25 percent.

Ms. TRUE. Thirty-six percent now. We never got up to 40. We are dropping.

Mr. WISE. Madam Chair, if I could just note that I don't pretend that West Virginia is one of the largest States in the country, but I think we have representatives of three of the largest States in the country, and nobody hit 60 percent. Somewhere the figures seem to be different.

The statistic has also been given that 90 percent of pregnant women are being served by this, by WIC. Does anyone care to comment? Is that true in your States? Does anyone think they are hitting close to 90?

Ms. STABENO. WIC in the State of Texas serves up to 185 percent of poverty. We are serving 40,000 women currently. The Medicaid service in Texas is reaching 62,000 pregnant women.

That tells me those are high risk women that we need to pick up in WIC if we have got a caseload slot available.

There are still pregnant women, between 133 and 185 percent and many may not be Priority I pregnant women. We have a long way to go. I dare say we are approaching 90 percent.

Mr. WISE. Does anything else care to comment on that?

Ms. GALE. In New York, we are serving about 59,000 pregnant women. That is because of the outreach efforts going on in our State to focus on our highest priority populations. We have done everything possible to get as many pregnant women on, but we have not hit 90 percentyet.

Ms. FERRIS. In West Virginia, there are about 22,000 births per year; 9,000 to 10,000 of those births occur to women on Medicaid or other MCH programs. Our average monthly caseload for pregnant women is somewhere around 7,000.

We know we are not hitting Medicaid. We don't feel we are addressing the other populations who are at 185 percent of poverty also.

Mr. WISE. Ms. Walker, your son is now how old?

Ms. WALKER. My son is 3½.

Mr. WISE. How is he doing? How is his development coming?

Ms. WALKER. Well, at this time he is underweight and he is learning disabled. He has a language delay and he has been in school since he was about 18 months old.

Mr. WISE. Do you have any concerns that because of these cutbacks he might be removed from the WIC Program? Do you think he will be able to continue to qualify?

Ms. WALKER. Well, at this time, from what I am hearing today, we might be cut. If we are, it will put us in dire straits. We are

already going to our church for assistance for food when we do not have the money to make it.

Mr. WISE. Dr. Ferris, if you could talk just a minute about—I am concerned about the rebate program. I think this is a short-term problem. I think the real bottom is coming in the next few months. We all hope this is a short-term situation we can deal with immediately, take care of it up to October 1 and then the new fiscal year.

Ms. Gale, your testimony, I think has been the most dramatic as to what the shortfalls could be. I just wonder, Dr. Ferris, what is going to happen to WIC roles in West Virginia given the present trend in rebate, in formula rebates?

Ms. FERRIS. Well, we were one of the States that got the 75 cent letter. That did cause us some concern.

We did some calculations recently. We think that it will impact our caseload, that we will have to drop another 2,000 participants off the rolls per month in West Virginia.

Mr. WISE. That is on top of the existing 2,000 that are already receiving notice; is that correct?

Ms. FERRIS. Yes, with the effect of inflation.

Mr. WISE. That is the situation we are in.

I just want to thank all of you for this testimony.

One final question. From what you have heard as State directors and those directly involved in the program, what do you see—and I suspect you have been through this before. I know we have had cutbacks in West Virginia and some of you have had it before. What kind of feeling did you come away with as you listened to the first two panels, particularly the FNS panel? Do you see things holding the line in your States? What projections do you make at this point?

Ms. STABENO. I will be glad to go.

We have anticipated that just to maintain our October 1989 levels, it is going to take $17.2 million. That is more than we will get if we get the same share we have gotten based on the House Budget Resolution and our own association's projections.

We are expecting that we won't be able to regain the numbers we served in 1990.

Ms. TRUE. In California, we are basically going to lose ground. We thought we had been able to add a substantial amount of caseload because of the rebates. We are losing it now. We have another year or more of the rebates. When those are whittled away by the formula companies, we will be back below where we started before the rebates.

Ms. GALE. I get very concerned when I see factsheets coming out of USDA like the one I saw today which actually shows the State of New York going up; comparing one year with a partial rebate with the next year at a full rebate, and then comparing our end of year caseload with the addition of State funds.

I have never seen apples and oranges quite arranged like this. I am very concerned about what is going to happen to our State's caseload due to inflation.

We have a large rebate now. We have our legislators and Governor supporting our program. Considering the way that we organize our money in one-twelfth increments, you can't overlook the fact

that in October one-twelfth Federal funds paid for 341,000 New Yorkers and in April, the same one-twelfth only covers 309,000.

When I hear USDA saying they aren't going to necessarily make adjustments for this year when they defend their past inflationary approaches and are only thinking about looking at other approaches, I am concerned that we are still on the road to rapid decline for WIC caseload. That is what we are preparing for.

Ms. FERRIS. We are not optimistic about our West Virginia caseload either. With West Virginia's share of a possible $150 million increase, and if we have to live with a 75 cent rebate, we project only an additional $2,000 for the entire fiscal year next year. That is not enough for significant growth or to make up our lost ground.

Mr. WISE. I want to thank you for calling this hearing, Madam Chair. I want to thank the panel and say I started out talking about Monet, who is 1 year old, whose sister was cut off by the age of 2. My hope is this Congress acts in time so that Monet is able to keep her benefits. She seems to be doing well. Thank you very much.

Mrs. BOXER. Thank you very much, Mr. Wise.

Thank you very much to the panel. You have been a very important part of this debate.

I know you waited around and I know I had to cut you short. But I want you to understand that what you did today may well push this Congress into action. If it does, you can really feel that you did make a difference. I will tell you you have made a difference to this Task Force.

As I go over now to the House floor, I am going to talk about what we learned here today and try to push through a remedy for this problem, both a short-term and a long-term fashion.

Thank you very much for your contribution. The Task Force stands adjourned.

[The following additional information was submitted for the record:]

[From the Washington Post, Wednesday, June 27, 1990]

Food Costs Curb Nutrition Program

WIC ROLLS TO BE CUT BECAUSE OF RISING PRICES, STATE DIRECTORS SAY

(By Spencer Rich)

Washington Post Staff Writer

Between 242,000 and 280,000 participants must be removed from the special nutrition program for low-income pregnant women, infants and children (WIC) by September because of rising milk, cheese and fruit prices, state program directors said yesterday.

The Agriculture Department program finances vouchers for special food such as infant formula, juices and cereals, for about 4.6 million women, infants and children up to age 5 who are determined by public health centers and clinics to be at risk of serious nutritional deficiencies. The $2.1 billion Congress provided for the program in fiscal 1990 is enough to serve half those who are eligible, according to Dennis H. Bach, president of the National Association of WIC Directors. Bach released a survey on expected cuts yesterday.

But because milk, cheese and fruit prices have risen at two to three times the 4.5 percent rate projected earlier by the Agriculture Department, some states are running short of funds and are beginning to cut their rolls and reduce the amount of special food given to each participant, he said. The Agriculture Department has not requested and Congress has not provided an additional $72 million needed to avoid cuts this year, although the House budget resolution seeks to boost next year's funds by $235 million, Bach said. But the Agriculture Department has reprogrammed about $11 million for WIC in needy states.

"It takes about six months for anemia to show up in lab tests," said Lynn McElroy, director of the Oklahoma program. But before the anemia becomes apparent, she said, children with inadequate nutrition are already beginning to experience less resistance to disease, reduced levels of alertness and other reactions to inadequate diet.

David Paige, a professor of public health at Johns Hopkins University, said the program is designed to ensure that a pregnant woman receives enough nutrients to guarantee normal development of her fetus and that infants get enough to develop their skulls and neurological systems and avert low birth weight, a primary cause of infant mortality.

The survey released by Bach estimated that the WIC rolls in 25 states would have to be cut a total of 242,239 by September. Other states did not face cuts because they were not using funds as quickly. Robert Greenstein, a former director of the Agriculture Department's Food and Nutrition Service and now head of the Center on Budget and Policy Priorities, said a follow-up survey by his group this week found that at least 27 states face caseload reductions totaling nearly 280,000 even after reprogramming the $11 million. An earlier Agriculture Department survey put the caseload reduction at 239,223.

A department spokesman said that even if the program drops to 4.4 million by year's end, it still is serving more people than a year ago.

OPENING STATEMENT OF HON. TONY P. HALL, CHAIRMAN, SELECT COMMITTEE ON HUNGER

I want to thank Chairman Boxer for calling this important hearing this morning. The subject of this hearing is children who are at risk -- or may actually be -- anemic, malnourished, and deprived of their main source of a decent, nutritious diet, and to see if there's anything that Congress can do about it.

Back in April, the Select Committee conducted a state-by-state survey of state WIC Administrators, which revealed a nationwide shortfall, affecting 34 states, and totalling $67 million. Worst of all, we found that more than half the states were beginning to actually drop eligible women and children from their program.

The new National Association of WIC Directors survey shows that the situation now is even worse than we first thought.

I'm a supporter of the WIC Program. My first hearing as Chairman of the Hunger Committee was on the National WIC Evaluation, establishing finally just how effective WIC was at reducing infant mortality, increasing maternal weight gain, increasing head size, and generally improving the nutritional status of participants. I've seen the evidence that WIC saves $3 in health care costs dollars for every dollar spent.

I don't understand how we can have a program that is as beneficial as WIC is, as effective

as WIC is, as cost efficient as WIC is, and deny it to half the people who need it. I don't understand how we can bail out the S&L Administrators -- at a cost of $500 BILLION -- and we can't find a fraction of that money to feed hungry children. I know money's tight, but, as the saying goes, it's hard to tighten your belt when you're wearing diapers.

I introduced legislation yesterday -- the WIC Services Restoration Act -- that would provide a quick-fix to the crisis in state WIC programs, allowing them to use surplus funds this year, and to borrow against next year to make up the shortfall and put the children back on the program. I'm anxious to hear what our witnesses think about the legislation.

But we'll never be able to really solve the problem until everybody recognizes this fact: WIC ought to be available to everybody who needs it.

We don't send only half our children to school, we don't give only half our children clothing or shelter. There's no reason that only half of the children eligible for WIC should get a nutritious diet.

I supported an increase of $150 million in WIC because I believe WIC should be expanded. It's pretty clear to me now that expanding WIC is going to cost more than $150 million. But I think it's worth it. I think it's high time we made the health of our most vulnerable children a national priority. Again, Madam Chairman, and Chairman Miller, I want to thank you for holding this hearing this morning.

PREPARED STATEMENT OF HON. BILL EMERSON

I WANT TO THANK CHAIRMAN BOXER FOR CALLING THIS IMPORTANT AND WORTHWHILE HEARING ON THE WIC CRISIS WHICH IS CURRENTLY FACING OUR NATION. I AM A STRONG SUPPORTER OF THE WIC PROGRAM. IT IS A PROGRAM THAT HAS RECEIVED BROAD SUPPORT IN THE CONGRESS AND OVER THE PAST DECADE HAS EXPANDED IN ALL STATES. GIVEN THE UNQUESTIONED VALUE OF THE WIC PROGRAM TO THE NATION'S FUTURE -- THE HEALTH OF ITS CHILDREN -- I BELIEVE THAT WE IN CONGRESS SHOULD FIND A WAY TO ADDRESS THIS SITUATION NOW AND IN THE YEARS AHEAD.

I WAS ENCOURAGED TO HEAR THAT USDA WILL BE REALLOCATING $11 MILLION FOR THE WIC PROGRAM. ACROSS THE COUNTRY, THESE ADDITIONAL 300,000 FOOD PACKAGES WILL SPELL RELIEF TO NEEDY CLIENTS OVER THE NEXT THREE MONTHS. ALTHOUGH THESE ADDITIONAL FUNDS WILL BE A STEP IN THE RIGHT DIRECTION IN ASSISTING THE STATES TOWARDS SERVING AS MANY CLIENTS AS POSSIBLE, MUCH REMAINS TO BE DONE.

I KNOW WE HERE TODAY DO NOT WANT TO SOLVE THIS CRISIS WITH A "BAND AID" APPROACH. THE SITUATION IS SERIOUS, THE NEED IS THERE, IT MUST BE MET, AND WE MUST WORK TOGETHER TO FIND A SOLUTION SO THAT WE CAN AVOID THIS CRISIS IN THE FUTURE. THOSE THAT ARE AFFECTED -- THE INFANTS AND CHILDREN -- ARE NOT IN A POSITION TO COME AND TESTIFY AT THIS HEARING. WE MUST REPRESENT THEIR INTERESTS FOR THEM; AFTERALL, THEY ARE THE FUTURE OF THIS COUNTRY.

PREPARED STATEMENT OF BETTY JO NELSEN

Madam Chairman, thank you for the invitation to be here today to discuss the Special Supplemental Food Program for Women, Infants and Children (WIC) for 1990. The Bush Administration has demonstrated its support for the WIC Program by making it a priority in the last two Federal budgets. I appreciate the opportunity to share with you our concern and management strategies for this important Program. At the Food and Nutrition Service we have been working cooperatively with State WIC Agencies and local programs since March when we first realized the impact of the unexpected spike in food prices. Briefly stated:

- High priority pregnant or breastfeeding women, and high priority infants receiving services as of March, 1990, will continue to be served. In all but one or two States, new applicants in these high priority groups are being added to the program rolls.

- Unspent funds are being reallocated. USDA is now completing the reallocation of $11 million dollars in unspent funds that will help States to deal with the tight funding situation. These funds are allocated to States according to a funding formula that ensures equity for all States. However, it will not be sufficient to meet the need for all States for all caseload.

- While some States will experience caseload declines from the peak levels earlier this year, as many as 20 States will maintain or increase participation for the last half of 1990, despite funding constraints.

- Nationally, we anticipate another record year of WIC participation. During FY 1990, WIC will serve an average of over 4.4 million participants--an all time high; an increase of about 6% over the number served in FY 1989. We are pleased that WIC continues to grow, but like you, we had hoped the record would be even better.

In addition, I have issued a directive to all Food and Nutrition Regional Offices to make sure that the States provide information about applying for Food Stamp benefits to WIC applicants unable to obtain WIC benefits, as required in the Child Nutrition and WIC Amendments of 1989 (P.L. 101-147).

Madam Chairman, at the beginning of this fiscal year, no one could have predicted the events that led to these higher program costs. Food price inflation has been significantly higher than projected particularly for juice and dairy products that comprise a major portion of the food package. No one could have predicted that a freak winter freeze would occur and therefore drive up the price of orange juice. Prices for the dairy items, and particularly cheese in the package were up as well. Yet, despite this greater than expected increase in WIC food prices, the average WIC participation for this fiscal year will be at an all time high.

Let me emphasize again, WIC Program expansion has grown steadily and continues to grow. In FY 1989, WIC served a monthly average of 4.1 million participants. Participation in FY 1990 is expected to average 4.4 million. In FY 1986, the program was serving about 40% of those eligible, but because of the steady growth in participation, WIC is now serving 60% of the eligible population.

USDA data show that WIC is currently serving:

- Almost all infants eligible for the program. We estimate that about one-third of all babies under the age of one are being served by the WIC program.

- About 90% of eligible pregnant women. This represents one-fifth of all expectant mothers in the U.S.

Despite the unforeseen problems that I discussed earlier, WIC State agencies have acted quickly and responsibly to reduce the cost of the food package and minimize the effects of the food price inflation without compromising the nutritional elements. For example, clients have been asked to shop for generic brand products which are lower in price than nationally advertized brands; substitute milk for cheese, beans for peanut butter; and buy more economical (larger) package sizes of food. Where necessary, restrictions have been placed on certifications to target limited resources to highest priority clients. Working with the States, we believe we have managed the program so that all clients with medically related nutritional risks have been served, and all but two States now are in a position to continue to reach the highest priority cases for the remainder of the year.

WIC, unlike the Food Stamp or School Lunch programs, does not have uniform national standards for eligibility. States have considerable latitude to establish their own nutritional risk criteria. For example, the hematocrit value for pregnant women, which identifies anemia, varied in Fiscal Year 1989 from 30 percent or less to 37 percent or less. Significant variation also exists in the way States define "dietary deficiencies," another index of nutritional risk. These differences among States create differences in program access so that applicants may be eligible in one state and not in another. This difference also relates to program costs and unmet need.

We have taken some initiatives to avoid this funding situation in the future:

- USDA will be working with the States to help them develop ways to obtain the most current cost information for items in the WIC food package throughout the year. We will be working with the Bureau of Labor Statistics and the Department's Economic Research Service on this effort. A meeting will be held in early July to discuss the development of a WIC specific inflation index as well as ways to obtain early national information on the cost of specific items in the WIC food package.

- USDA will be working with the States to improve systems for monitoring monthly participation changes and State grant expenditures. FNS has developed a reporting system for States to use to present food cost and participation plans for the Fiscal Year, which will updated as conditions change.

For FY 1991, the Administration has requested $2.215 billion; an increase of more than four percent over last year's appropriation which is consistent with our commitment to an effective WIC program. With this amount, we estimate that for FY 1991 we could serve 4.2 million participants. However, that estimate is very uncertain due to the unpredictability of the infant formula rebates. We will be monitoring the contract process closely in the months ahead.

In closing, let me say that even when food prices are stable and predictable the WIC program is difficult for State Directors and local program operators to manage because there are so many variables. However, this has been a very difficult year for WIC program mangers at all levels. Tough decisions had to be made by the local program staff, State agencies, and FNS. These staff are to be commended for their exemplary performance. Our appreciation is extended also to the participants who have contributed to the caseload management efforts. They may have had to accept a limited food package or have helped the program by purchasing lower priced food items. Everyone has worked together and the cooperation and understanding is truly remarkable.

Madam Chairman, that concludes my testimony. I would be happy to answer any questions.

Attachment.

31-597 - 90 - 3

United States Department of Agriculture

Food and Nutrition Service

3101 Park Center Drive
Alexandria, VA 22302

June 14, 1990

FNS UPDATE ON WIC

STATUS REPORT

Following is an up to date State-by-State picture of the consequences of unexpectedly high food costs on WIC participation.

No high priority pregnant or breastfeeding women or high priority infants receiving services as of March are being removed. Further, in all but one or two States, new applicants in these high priority groups are being added to the program rolls (a description of the WIC priority system is enclosed). Participation in the program reached an all-time high in March. While some States will experience declines from these participation levels, as many as 20 States will maintain or increase participation from March through the end of Fiscal Year 1990. (See enclosed tables.) Additionally, another 5-10 States, including Illinois, Ohio, and Pennsylvania, will experience little if any participation decline from March levels. All States have taken appropriate management strategies to avoid year-end funding shortfalls.

MANAGEMENT ACTIVITIES

States with funding difficulties have addressed their problems by undertaking one or both of two major management actions. First, many States avoided large participation declines by adjusting food package requirements/options. (Adjustments are noted on the enclosed tables.) Second, enrollment moratoria were effected for lower priority participants -- participants in Priority IV or V whose participation was based on dietary inadequacies rather than medically related nutritional conditions such as anemia. Current information from WIC State agencies indicates that only two States -- Oklahoma and Utah -- have had to place enrollment moratoria as high as Priority III. Finally, USDA is now completing a reallocation of $11 million in unspent WIC funds from last year. This money will help States to deal with the tight funding situation. Given the magnitude of inflation in the WIC food package this year, we believe it is commendable that States have managed through these difficult times as well as they have.

LOOKING AHEAD

USDA staff and WIC State agency directors are working to develop a set of strategies to better respond to WIC food inflation. First, States and USDA will set up a system to obtain current cost information for items included in WIC food packages. Second, USDA will work with States on a system to monitor monthly changes in projected participation based on current grant expenditures. This is being done so that any necessary adjustments in participation levels or food packages may be considered as early in the year as possible. Again, timely information is the goal.

Enclosures

NOTE: Data was submitted by WIC State agencies to FNS between June 8 and 13, 1990.

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WIC PROGRAM

STATE AGENCY	(A) FY 1989 AVERAGE PARTI-CIPATION	(B) MARCH 1990 PARTI-CIPATION	(C) FY 1990 AVERAGE YEAR-TO-DATE PARTICIPATION	(D) PARTICIPATION PROJECTION-END OF FY 1990	(E) REALLOCATION AMOUNT	(F) STATE-APPROPRIATED FUNDS
ALABAMA	86,349	97,175	95,323	N/A	$0	$0
ALASKA	7,165	9,897	10,245	N/A	$9,407	$1,017,000
ARIZONA	38,811	46,844	43,590	43,540	$268,601	$100,000***
ARKANSAS	54,025	56,999	54,880	N/A	$370,537	$0
CALIFORNIA	390,628	485,871	476,317	429,598	$1,422,431	$0
COLORADO	45,551	48,982	47,606	39,500	$91,733	$0
CONNECTICUT	46,875	51,552	49,615	48,000	$44,279	$0
DELAWARE	9,568	11,727	11,010	12,300	$0	$160,000
DISTRICT OF COL	11,531	13,723	13,375	14,763	$12,881	$600,000
FLORIDA	159,524	197,802	188,961	174,700	$693,139	$0
GEORGIA	153,171	170,997	169,466	150,517	$297,474	$0
GUAM	2,764	2,935	2,797	N/A	$8,867	$0
HAWAII	12,875	15,467	14,788	14,500	$0	$0
IDAHO	20,616	22,127	20,973	N/A	$117,228	$0
ILLINOIS	165,311	194,775	191,524	N/A	$517,904	$6,600,000
INDIANA	85,683	105,787	101,303	109,350	$358,805	$200,000
IOWA	44,335	48,792	47,125	45,000	$150,472	$200,000***
KANSAS	34,931	40,921	41,920	40,000	$118,026	$300,000
KENTUCKY	83,126	92,741	90,957	90,000	$158,623	$0
LOUISIANA	108,507	114,861	111,810	N/A	$0	$0
MAINE	19,311	21,706	19,527	22,688	$57,549	$0
MARYLAND	44,528	59,981	53,042	63,000	$167,096	$0
MASSACHUSETTS	64,026	72,002	72,668	78,700	$169,027	$5,756,447
MICHIGAN	141,658	147,005	143,217	N/A	$215,490	$396,500
MINNESOTA	69,670	77,451	74,731	74,500	$129,346	$750,000
MISSISSIPPI	96,025	101,542	98,904	N/A	$0	$0
MISSOURI	77,214	91,344	88,487	83,000	$283,778	$0
MONTANA	14,165	15,477	14,447	MAINTAIN	$41,174	$0
NEBRASKA	20,642	21,751*	20,070	N/A	$61,030	$0
NEVADA	13,861	16,224	15,694	15,700	$26,719	$0
NEW HAMPSHIRE	13,933	16,278	14,940	10,400	$16,223	$100,000
NEW JERSEY	78,091	93,997	91,422	102,805	$294,132	$750,000***
NEW MEXICO	31,042	28,697	26,495	N/A	$68,983	$0
NEW YORK	312,180	316,053	331,296	361,000**	$1,033,117	$42,350,000

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WIC PROGRAM

STATE AGENCY	(A) FY 1989 AVERAGE PARTI-CIPATION	(B) MARCH 1990 PARTI-CIPATION	(C) FY 1990 AVERAGE YEAR-TO-DATE PARTICIPATION	(D) PARTICIPATION PROJECTION-END OF FY 1990	(E) REALLOCATION AMOUNT	(F) STATE-APPROPRIATED FUNDS
NORTH CAROLINA	122,473	138,689	135,091	127,000	$323,085	$0
NORTH DAKOTA	14,250	15,478	15,378	14,613	$25,145	$0
OHIO	186,109	199,659	192,287	197,800	$286,840	$0
OKLAHOMA	42,708	55,815	53,112	40,271	$195,547	$0
						$0
OREGON	45,657	49,362	48,439	49,500	$219,926	$0
PENNSYLVANIA	176,227	180,205	176,920	180,189	$554,853	$15,000,000
PUERTO RICO	116,360	133,769	133,944	114,500	$551,264	$0
RHODE ISLAND	14,339	16,385	16,024	15,876	$13,195	$0
SOUTH CAROLINA	79,022	90,481	82,753	N/A	$0	$0
SOUTH DAKOTA	14,653	16,536	16,043	MAINTAIN	$58,121	$0
TENNESSEE	91,797	95,594	97,377	N/A	$0	$0
TEXAS	310,991	341,986	339,922	325,000**	$1,160,818	$5,202,000
UTAH	41,777	45,423	45,210	24,000	$191,668	$0
VERMONT	14,563	15,202	14,977	15,300	$15,241	$0
VIRGIN ISLAND	6,039	5,068	4,968	8,500	$0	$0
VIRGINIA	77,380	92,301	83,403	90,500	$264,946	$0
WASHINGTON	51,266	59,878	55,143	60,000	$182,096	$548,000
WEST VIRGINIA	32,079	36,853	34,075	34,750	$101,088	$0
WISCONSIN	70,208	71,858	70,255	69,161	$154,914	$3,007,300
WYOMING	9,240	9,369	9,395	8,000	$11,419	$200,000***
TOTAL	4,074,830	4,579,394	4,473,241			

SOURCES OF DATA:

Column A - reflects March 1990 participation data obtained from monthly reports submitted by WIC State agencies. (WI-129 Management Report dated 05/22/90.)

Column B - Average Year-to-Date Participation data for Oct. through March of Fiscal Year 1990 were obtained from monthly reports submittted by WIC State agencies. (WI-129 Management Report dated 05/22/90.)

Column C - The average Fiscal Year 1989 participation data were obtained from monthly reports submitted by WIC State agencies. (WI-129 Management Report dated 05-22-90.)

Column D - State projection of end of year participation.

Columns E & F - Self-explanatory.

Column G - Priorities served as reported to FNS; where blank, no information provided.

Column H - Food package adjustments as reported to FNS; where blank, no information provided.

(*) indicates amount estimated due to missing month report.
(**) indicates sum of Federal and State participation.
(***) indicates WIC contingency funds.
(****) Effective July 1, Georgia will not serve all Priority III applicants.
N/A = funding sufficient to maintain or increase participation; no specific participation projection available.

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STATE AGENCY	(G) CURRENT PRIORITIES SERVED	(H) COMMENTS
ALABAMA		Economical Container Sizes; Beans for P-Nut Butter.
ALASKA	I-III	
ARIZONA	I-III	P-Nut Butter as Option Every Other Month.
ARKANSAS		
CALIFORNIA	I-III	No Cheese for Certain Pkgs; Reduced Juice For Kids 1-3.
COLORADO	I-IV	No P-Nut Butter; Encourage Less Expensive Brands
CONNECTICUT	I-V	Store Brands; Beans for P-Nut Butter
DELAWARE	I-VI	
DISTRICT OF COL	I-VI	
FLORIDA	I-IV (X-CEPT IV-PPW)	Economical Container Sizes; Beans for P-Nut Butter; Adjusting Dairy Products.
GEORGIA	I-III (+IV PREGNANT)****	Economical Container Sizes; Beans for P-Nut Butter.
GUAM		
HAWAII		No P-Nut Butter or Cheese in Standard Package.
IDAHO		
ILLINOIS		
INDIANA	I-VI	Eliminated Cheese and 1 Dozen Eggs
IOWA	I-V	
KANSAS	I-IV	
KENTUCKY	I-V	Economical Container Sizes; Beans for P-Nut Butter; Reducing Dairy Quantities.
LOUISIANA		
MAINE		Encourage Low Cost Brands
MARYLAND	I-VI	
MASSACHUSETTS	I-IV	No High Cost Cheeses, Orange Juice and Cereals.
MICHIGAN		
MINNESOTA	I-VI	No Food Package Alterations
MISSISSIPPI		
MISSOURI	I-IV	Store Brands; Least Expensive Cheese, Milk and Frozen or Canned Juice.
MONTANA	I-V	
NEBRASKA		
NEVADA	I-VI (X-CEPT V-CHILD & VI PPW)	Economical Container Sizes; Eliminating High Cost Cereals.
NEW HAMPSHIRE	I-VI	Store Brands; Economical Container Sizes
NEW JERSEY	I-VI	Store Brands; Eliminated High Cost Cereals
NEW MEXICO		
NEW YORK		Economical Container Sizes.

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STATE AGENCY	(G) CURRENT PRIORITIES SERVED	(H) COMMENTS
NORTH CAROLINA	I-IV	Economical Container Sizes; Beans for P-Nut Butter.
NORTH DAKOTA	I-IV	Revised Standard Package and Tailoring Guidelines.
OHIO	I-V	No P-Nut Butter
OKLAHOMA	I-II (HIGH RISK IIIs)-NO NEW PART. AT ANY PRIORITY	Beans for P-Nut Butter; Least Costly Milk, Juice, and Eggs; Dairy Adjustments.
OREGON	I-III	Eliminating High Cost Cereals and Juices; Limiting Cheese and Juice for Kids.
PENNSYLVANIA	I-VI	
PUERTO RICO	I-III (NORMAL PRACTICE)	
RHODE ISLAND	I-IV	Economical Container Sizes
SOUTH CAROLINA		Economical Container Sizes; Beans for P-Nut Butter.
SOUTH DAKOTA	I-VI	
TENNESSEE		Economical Container Sizes; Beans for P-Nut Butter.
TEXAS	I-III	Dairy Product Adjustments (milk for cheese).
UTAH	I-II	
VERMONT	I-VI	
VIRGIN ISLAND	I-VI	
VIRGINIA	I-V	
WASHINGTON	I-II (+ III-CHILDREN)	
WEST VIRGINIA	I-III	Economical Container Sizes; Eliminated Expensive Juices and Cereals.
WISCONSIN	I-IV	No P-Nut Butter or Cheese
WYOMING	I-III	Revising Child's Food Package to 1989 RDAs.

WIC NUTRITIONAL RISK PRIORITY SYSTEM

Local agencies serve categorically and financially eligible women, infants and children at nutritional risk on a first come, first serve basis until they achieve a service level that they can support with available funding. This is known as being "at caseload." From the point at which a local agency is at caseload, additional applicants are processed in a priority order from a waiting list as vacancies occur. This order is dictated by the priority system requirements of the WIC regulations. The purpose of the priority system is to target benefits to those most at risk at times when Program demand exceeds availability of resources. The seven priorities listed below tier applicants by their category and risk and need for WIC benefits, with first priority being pregnant and breast-feeding women and infants with documented nutritionally related medical problems.

Priority I - Pregnant women, breast-feeding women and infants at nutritional risk as demonstrated by hematological or anthropometric measurements, or other documented nutritionally related medical conditions which demonstrate the need for supplemental foods.

Priority II - Except those infants who qualify for Priority I, infants up to six months of age of Program participants who participated during pregnancy, and infants up six months of age born of women who were not Program participants during pregnancy but whose medical records document that they were at nutritional risk during pregnancy due to nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions which demonstrated the person's need for supplemental foods.

Priority III - Children at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions which demonstrate the child's need for supplemental foods.

Priority IV - Pregnant women, breast-feeding women, and infants at nutritional risk because of an inadequate dietary pattern.

Priority V - Children at nutritional risk because of an inadequate dietary pattern.

Priority VI - Postpartum women at nutritional risk[1].

Priority VII - (State agency option). Previously certified participants who might regress in nutritional status without continued provision of supplemental foods.

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[1]At State option, postpartum women may be placed in Priority group III, IV, V, or VI. States may subdivide postpartum women by nutritional risk in determining their priority group placement.

PREPARED STATEMENT OF DENNIS H. BACH

Thank you for the opportunity to appear before you today. My name is Dennis H. Bach. I am the Director of the Iowa WIC Program, and also the current president of the National Association of WIC Directors. It is in the latter role that I address you today.

The National Association of WIC Directors, N.A.W.D., is the organization that represents the state and local agency management of the Supplemental Food Program for Women, Infants, and Children. The goals of N.A.W.D. are to improve the management of the WIC Program, serve as a resource to its members, and do whatever is necessary to serve the interests of our clients. The people we serve are low income, nutritionally at risk pregnant, postpartum, and breastfeeding women, infants, and children up to the age of five.

There are two significant features of this population which should be kept in mind throughout the discussions which follow today. First, this is a particularly vulnerable population. WIC infants and children are at a critical stage of growth and development. Their nutritional well being during these years affects their potential for physical and intellectual growth and development throughout their life.

Second, it is a population that is critical to the future of this country. Recently, the Council on Economic Competitiveness issued a report detailing their priorities for the nation. At the top of the list, along with reducing the deficit, was support for increased funding of the WIC Program. This recommendation was prompted by their concern over whether this country would have a sufficient supply of healthy, productive workers twenty years in the future. They recognized the vital role that WIC can play in insuring that productive workforce.

WIC is designed as an intervention program. During this critical period of an infant or child's development, we provide nutritional supplements, education on how to maintain a healthy diet throughout life, and encouragement for ongoing health care. And then, when the child is no longer at nutritional risk, we go on to serve someone else.

The converse to this is that there is an opportunity cost for every child that is not served. If the government wants to build a highway or a jet plane but decides it cannot afford it this year, the government can wait and build it next year. However, an infant or young child cannot wait until the government decides it can afford to feed it. If the funding for the WIC Program is sufficient to serve only

60% of the eligible population, the federal government will pay the opportunity cost of not serving the other 40%.

There will undoubtedly be testimony today regarding WIC's effectiveness in reducing future health care costs. Suffice it to say that prevention of health problems through the WIC Program is less expensive than correction.

The WIC Program is not an entitlement. Each year, Congress weighs its priorities and then budgets and appropriates what it feels it can for the WIC Program. Those funds are provided to the United States Department of Agriculture which allocates them to the various states. State WIC Program managers then take those funds and stretch them to serve as many participants as possible. And that brings us to the heart of today's issue. Because of factors largely beyond the control of state managers, the existing funds cannot be stretched to serve as many participants as they were intended to. The federal fiscal year 1991 budget resolution passed by the House expressed the intent to provide $150 Million above the level theoretically necessary to maintain the current services baseline. However, the current services amount identified in the budget resolution will not be enough to support the existing caseload. At least one third, and possibly all of the additional $150 Million will be consumed by increases in the cost of the WIC food package.

Our Association recently completed a survey of states to determine what has been happening with food package costs. The results are summarized in a report which is included as an appendix to this testimony. I will not go into great detail on the findings, but will instead emphasize a couple of points.

The average increase in the cost of the WIC food package for just the first six months of FFY'90 was 7%. This is almost twice the increase USDA projected for the entire year. Some of the main culprits in this increase have been dairy prices and orange juice prices.

Many states have implemented policies to reduce the increase in cost through limiting the selection of WIC foods. Others have actually reduced the quantity of foods provided. Some restrictions on participant choice and some tailoring of quantities to meet nutritional needs is appropriate. However, if escalating cost pressures drive states to take these measures to extremes, the long term detriment to the program will far outweigh the short term savings. WIC will not be effective if a child will not eat the types of cereal available. WIC will not be effective if the value of the WIC food package is diminished to the point that a mother doesn't bother to come into the clinic anymore to get her WIC checks. We want to make sure that cost-cutting tricks are not seen as the primary solution to the current caseload dilemma.

We are also concerned about the recent trend in bids on infant formula rebate contracts. Rebate levels have steadily escalated during the last two years. Many of us predicted that they would eventually peak, fall somewhat, and then level off. I don't believe any of us would have predicted that they would fall as far and as rapidly as they have recently. The State of Nevada, for example, will lose approximately 45% of its current rebate savings, from $1.8 million per year down to $1 million. According to our survey, about nineteen and one half percent of the caseload - almost one in five WIC participants - is supported by infant formula rebate funds. If states lose a third to a half of their rebate funds as they re-bid contracts, hundreds of thousands of participants will be denied WIC services.

WIC formula rebates were a result of the initiative and ingenuity of state WIC directors, people like Jane Baxter of Tennessee, Betsy Clark of Oregon, Terry Williams of Wyoming, and Debra Stabeno of Texas. My colleagues will use what remaining flexibility they have under P.L. 101-147 to find creative ways to maximize their savings in future rebate contracts. However, it appears that a significant decline in rebate funds will occur in the next year.

I would like to make one final point. The decreases in WIC participation that are occurring this summer are unfortunate. For those women, infants, and children who are denied WIC benefits it will be tragic. But to understand the problem, it is necessary to go beyond the numbers in our report. Some states are not reducing caseloads now because they have restricted priorities, maintained waiting lists, and otherwise kept participation low enough all year. That still means that eligible women, infants, and children are being denied services. This situation will continue to exist as long as the funds are not sufficient to serve the eligible population. The problem may be more acute this year because of higher inflation and reduced rebates, but it is a chronic problem. The only solution to caseload fluctuations and restrictions is adequate funding to serve the population in need.

The Food and Nutrition Service of USDA has issued an analysis of the shortfall which I personally find quite disturbing. They indicate that the problem is not serious because no "high priority" women and infants (those with a medically related nutritional risk) are being denied service. Anytime a nutritionally at risk pregnant woman or infant is denied access to WIC it is serious.

The WIC priority system assigns women, infant, and child participants to different categories or levels of risk. However, all WIC participants, by definition are at risk.

Furthermore, USDA's analysis focuses on services to women and infants, and not on children. Toddlers do not stop being hungry and they do not cease to be at nutrition risk by virtue of having their first birthday. While some of the most dramatic evidence of WIC's effectiveness is related to prenatal services, there is also evidence of WIC's effect on health status and learning ability from services to young children.

During one of the presidential debates last fall, President Bush mentioned that he supported the W-I-C Program. WIC does stand for women, infants, and children. It is not the Women and Infants Program. The Assistant Secretary for Food and Consumer Services, Catherine Bertinni, has stated that service to children is a priority of this administration. We are looking for evidence of that commitment in USDA's perspective on WIC caseload restrictions.

The House has passed a budget resolution for FY'91, and action in the House Appropriation Committee appears imminent. We believe it is imperative that Congress appropriate at least the $2.235 Billion specified in the House Budget Resolution for FY'91. If Congress truly wants to expand the WIC Program next year, it will have to find additional funds above that level. It would be money well spent.

Again, on behalf of the National Association of WIC Directors, we appreciate your holding this hearing on the current WIC funding shortfall, and providing us the opportunity to share our concerns with you. I would be happy to answer any questions you have.

Attachment.

NATIONAL ASSOCIATION OF WIC DIRECTORS

FOOD PACKAGE COST AND CASELOAD MANAGEMENT SURVEY

The National Association of WIC Directors (NAWD) conducted a survey of all geographic and Indian state agencies in May 1990 to determine the current and historical trends in WIC food package costs, the impact of recent food package inflation on services to the eligible population, efforts of cost containment on program expansion and those status of caseload management in state WIC Programs. Response was received from 48 geographic state agencies and 10 Indian state agencies.

FOOD PACKAGE INFLATION

Of the state agencies reporting food package inflation information, the majority have experienced significant inflation in their participant food package costs in the past two years. Between Federal Fiscal Year (FFY) 1988 and 1989, 42 states reported inflation of 5 percent or greater. Of these states, 22 reported inflation above 7 percent. The effects of this inflation were offset by the number of states implementing rebates. There was a significant influx of new funds in the program, and in the majority of states, caseloads did not have to be cut in spite of unanticipated rising food costs.

Several states did in fact reduce caseload in FFY 1989 due to inflation. FFY 1990 data shows a further upward trend in the inflation that states are experiencing. As of March 1990, 46 states have reported food package inflation 5 percent or greater, with 33 reporting inflation greater than 7 percent. This represents the increase in just the first six months of the fiscal year. Inflation could continue to increase as the year progresses. The USDA-projected WIC food package inflation rate for FFY 1990 was only 4.5 percent. Food package inflation is a critical issue for the WIC Program. WIC participation is a function of the projected funding available for both food packages and direct nutrition and operational services. As food package inflation rises above the level which is funded, the program loses its purchasing power and thus cannot serve the level of participation that was projected. This is the situation the majority of states now face.

PROGRAM PARTICIPATION

Unanticipated food package inflation has a direct impact on the program's ability to serve the population at risk as well as on the continuation of the current level of services in many states. Of the states reporting, 41 were not serving all priorities as of June 8, 1990. Of the ten states with the highest participation, nine currently have caseload restrictions. These nine states constitute approximately 48 percent of the national WIC participation. The downward trend in participation as a direct result of the excessive food package inflation should be seen not only as it impacts on individual states, but rather that it impacts on approximately one half of those currently participating in the WIC Program.

In addition to the caseload cutbacks, some states have implemented policies to make changes in the food package. These changes range from elimination of some foods (i.e. peanut butter), reduced amounts of foods, packaging requirements (i.e. allow only gallons of milk), and price limitations (i.e. store brand only, no cereals greater than .16/ounce). The majority of these changes are ones that states have had as long standing policy in an effort to maximize program funds.

There are few options for further reductions. The WIC food package was designed to provide nutritional supplements to individuals at nutritional risk during critical times of growth and development (pregnancy, lactation, infancy and early childhood). There is a nutrient level below which the food package cannot be reduced or the effects of the program on pregnancy outcome and child growth and development will be diminished or not evident at all. This will cause the program to lose its effectiveness both as a health and nutrition program. An important adjunct of participation in WIC is the increased utilization of preventive health care programs, prenatal care, immunizations, and well child clinic services. A reduced food supplement has the potential of reducing participant interest in WIC, with a concurrent loss of the other services as well. Without further cost reductions options, states' only recourse is reducing caseload.

The survey indicated that approximately 245,000 fewer participants would be served by the WIC Program between March 1990 and September 1990 as states trim their caseloads to make up for the excessive inflation earlier in the year. These numbers include only data current as of June 10, 1990. As states continue to update participation and fiscal reports the number will increase.

The need and demand for the WIC Program has increased significantly in the past three years. The WIC Program is serving approximately one million more eligible women, infants, and children than it did in FFY 1988. This expansion has been one of the results of the national efforts to prevent infant mortality, the recently enacted changes in Medicaid for pregnant women, infants and children, and the growth funds available as a result of infant formula rebates and increased Congressional appropriations. Now some of these at-risk individuals intended to be served by Congress will be denied supplemental foods.

REBATE SUPPORT OF THE PROGRAM

In the past three years, infant formula rebates have been the single most important resource which has allowed states to expand the WIC Program to reach more of the eligible population. In FFY 1988, 11 states reported infant formula rebates supporting food expenditures. In FFY 1990 all states are required to implement a form of cost containment, with infant formula rebates being the primary form. Of the states reporting, 34 use infant formula rebates to support 10 percent or greater of their caseload. Fifteen states use infant formula to support more than 20 percent of their caseload.

One such example is Nevada. In 1988 Nevada implemented a sole source system of infant formula rebates. They received $ 1.30 per can of infant formula. In May 1990 the contract was re-bid and the highest savings were found in an open market system with varying rebate levels. The highest rebate will be from Mead Johnson at $1.00 per can, representing approximately 60 percent of the market share. The second highest is Ross Laboratories at $.75 per can with 35 percent of the market share. The sole provider bids were even less. Nevada cannot continue to support the current services level with this decrease in rebate funding.

The NAWD survey showed that, of the responding states, 795,000 participants, or 19.5 percent of the reported caseload, was supported by rebate funds. A one-third loss in rebate revenues by other states, as was experienced by Nevada, would result in additional caseload lost to the program.

This financial support of the program through rebates is a concern because is not "hard" funding which can be counted on from one year to the next. A number of other states like Nevada which recently rebid their contracts will be receiving less rebate per unit of infant formula.

SUMMARY

The WIC Program has been widely recognized as an effective program which improves birth outcomes and early childhood nutritional status, resulting in the savings of public funds in interventive health care. The caseload losses as a result of runaway food cost inflation represent a major step backward in a program continuously expanded by Congress due to its proven cost benefit. The results of this study, and the continuing downward trend each time these figures are updated, demonstrate that WIC is at a critical crossroad in its ability to continue the present level of services without relief from the uncontrollable increases in the costs of the WIC food supplements.

The attached table provides state specific information regarding the projected caseload decreases for the remainder of the year.

NATIONAL ASSOCIATION OF WIC DIRECTORS - PARTICIPATION AND FUNDING SURVEY
TELEPHONE FOLLOW-UP TO MAIL SURVEY - JUNE 4-8, 1990

PARTIAL LIST OF STATES IMPLEMENTING REDUCTIONS IN PARTICIPATION DURING FY'90

STATE	PROJECTED CASELOAD CUTS	FUNDS NEEDED TO AVOID CUT	PRIORITIES NOT SERVED
COLORADO	10,000	$1,800,000	5,6
IOWA	4,000	$600,000	6
MISSOURI	14,000	$4,700,000	5,6
NORTH DAKOTA	800	$150,000	5,6 (4 YR OLD)
WYOMING	1,400	$300,000	5,6
UTAH	12,000	$1,500,000	3,4,5,6
RHODE ISLAND	509	$236,051	5,6
MAINE	1,062	$173,360	
PUERTO RICO	16,000	$2,000,000	4,5,6 (3 PARTIAL)
WEST VIRGINIA	2,096	$487,200	4,5,6 (3 PARTIAL)
TEXAS	27,000	$6,500,000	4,5,6
OHIO	2,659	$1,150,000	
OKLAHOMA	15,600	$2,500,000	4,5,6 (3 PARTIAL)
CALIFORNIA	36,000	$14,500,000	4,5,6, (2,3 PARTIAL)
NORTH CAROLINA	10,000	$3,000,000	5,6
NEW HAMPSHIRE	1,274	$244,608	6 (4,5 PARTIAL)
NEW YORK	31,000	$20,700,000	4,5,6 (3-93 AGENCIES)
FLORDIA	25,000	$3,100,000	5,6
GEORGIA	17,000	$4,000,000	3,4,5,6
CONNECTICUT	4,000	$335,000	6
ARIZONA	3,000	$613,680	4,5,6, (3 PARTIAL)
OREGON	2,000	$1,000,000	4,5,6
ALASKA	2,500	$1,900,000	4,5,6 (3 PARTIAL)
HAWAII	1,000	$400,000	5,6
NEVADA	500	$120,000	6
CHEROKEE (NC)	50	$30,000	5,6 (4 PARTIAL)
CHOCTAW, MS	100	$50,000	
MANILAQ (AK)		$25,000	5,6
CHICKASAW	492	$120,000	1-6 (WAITING LIST)
CHOCTAW, OK	750	$29,250	4,5,6
POTAWATOMI	234	$10,000	4,5,6
ISLETA PUEBLO	100	$18,000	5,6
PUEBLO ZUNI	41	$11,654	5,6
SANTO DOMINGO	30	$2,000	7
PUEBLO SAN FELIPE	52	$2,000	5,6
TOTAL	242,249	$72,307,803	

NOTE: This is a partial list, as all states were not able to be reached for the survey. Data represents states' best point in time estimates. Numbers may change as updated data becomes available.

NATIONAL ASSOCIATION OF WIC DIRECTORS - SURVEY DATA, MAY 1990

ANNUAL RATE OF INCREASE IN THE WIC FOOD PACKAGE

STATE	FFY1988	STATE	FFY1989		YEAR TO DATE INCREASE FOR FFY1990
ALASKA	15.0%	POTAWATOMI	15.0%	RHODE ISLAND	15.0%
CONNECTICUT	13.6%	MAINE	13.1%	WEST VIRGINIA	14.0%
WYOMING	11.7%	WEST VIRGINIA	13.0%	CALIFORNIA	13.4%
WASHINGTON, D.	10.3%	ALASKA	12.0%	ILLINOIS	12.7%
VIRGINIA	9.8%	CONNECTICUT	11.0%	UTAH	12.6%
WEST VIRGINIA	8.0%	MONTANA	10.9%	WYOMING	12.6%
RHODE ISLAND	7.8%	E CHEROKEE	10.3%	KENTUCKY	12.0%
PENNSYLVANIA	6.9%	ITCN NEV	10.0%	NEW YORK	11.4%
NEW JERSEY	6.9%	NEW MEXICO	10.0%	CONNECTICUT	11.1%
WISCONSIN	6.9%	N CAROLINA	10.0%	POTAWATOMI	11.0%
N CAROLINA	6.6%	WISCONSIN	9.1%	PENNSYLVANIA	10.9%
ROSEBUD	6.0%	ARIZONA	9.1%	WISCONSIN	10.7%
TEXAS	5.6%	HAWAII	9.1%	NEBRASKA	10.6%
ALABAMA	5.4%	PENNSYLVANIA	8.9%	VIRGINIA	10.3%
OHIO	5.3%	COLORADO	8.8%	NEVADA	10.2%
CALIFORNIA	5.3%	VERMONT	8.7%	S CAROLINA	10.1%
CHOCTAW OK	5.0%	IOWA	8.5%	NEW HAMPSHIRE	9.7%
MAINE	5.0%	NEBRASKA	8.3%	TEXAS	9.7%
NEBRASKA	4.9%	WASHINGTON, D.	8.2%	NEW MEXICO	9.6%
SOUTH DAKOTA	4.9%	5 SANDOVAL	8.0%	FLORDIA	9.3%
INDIANA	4.9%	CALIFORNIA	7.9%	MAINE	8.8%
HAWAII	4.5%	ALABAMA	7.8%	KANSAS	8.7%
KENTUCKY	4.3%	SOUTH DAKOTA	7.0%	WASHINGTON, D.	8.6%
MINNESOTA	4.1%	OREGON	6.9%	COLORADO	8.5%
MISSOURI	4.0%	ILLINOIS	6.9%	ARIZONA	8.4%
INTERTRIBAL OK	4.0%	RHODE ISLAND	6.3%	NORTH DAKOTA	8.0%
CHEROKEE OK	4.0%	UTAH	6.3%	OHIO	7.9%
TENNESSEE	4.0%	KENTUCKY	6.2%	IOWA	7.8%
COLORADO	3.1%	NEW HAMPSHIRE	6.1%	MASSACHUSETTS	7.6%
NEW HAMPSHIRE	3.0%	ROSEBUD	6.0%	CHEYENNE RIVER	7.4%
PUERTO RICO	2.9%	KANSAS	6.0%	OREGON	7.3%
MASSACHUSETTS	2.7%	OHIO	6.0%	MINNESOTA	7.3%
IOWA	2.5%	NEVADA	5.7%	NEW JERSEY	7.1%
ITCN NEV	2.0%	NEW JERSEY	5.5%	TENNESSEE	7.0%
S CAROLINA	1.9%	MISSOURI	5.4%	INTERTRIBAL OK	7.0%
VERMONT	1.0%	MINNESOTA	5.4%	VERMONT	6.7%
NEVADA	0.9%	NEW YORK	5.2%	MARYLAND	6.7%
NEW MEXICO	-1.0%	TENNESSEE	5.0%	N CAROLINA	6.6%
FLORDIA	-2.0%	PUERTO RICO	5.0%	ALABAMA	6.6%
UTAH	-4.5%	CHEROKEE OK	5.0%	SOUTH DAKOTA	6.3%
		CHOCTAW OK	5.0%	MONTANA	6.3%
		INTERTRIBAL OK	5.0%	ROSEBUD	6.0%
		ARKANSAS	4.7%	ALASKA	6.0%
		INDIANA	4.2%	PUERTO RICO	5.9%
		VIRGINIA	4.0%	INDIANA	5.6%
		MASSACHUSETTS	3.3%	HAWAII	5.1%
		WYOMING	2.9%	MISSOURI	4.9%
		FLORDIA	2.4%	CHEROKEE OK	4.4%
		TEXAS	2.2%	CHOCTAW OK	4.0%
		NORTH DAKOTA	2.0%	ITCN NEV	2.5%
		CHEYENNE RIVER	1.5%	WASHINGTON	1.1%
		WASHINGTON	1.0%	VIRGIN ISLANDS	1.0%
		VIRGIN ISLANDS	1.0%	ARKANSAS	-0.4%
		S CAROLINA	-1.0%	5 SANDOVAL	-2.0%

NATIONAL ASSOCIATION OF WIC DIRECTORS - SURVEY DATA, MAY 1990

STATES RANKED BY PERCENT OF CASELOAD SUPPORTED WITH INFANT FORMULA REBATE FUNDS

FFY'88		FFY'89		FFY'90		FFY'90	
NEW MEXICO	19.3%	ALABAMA	29.0%	TENNESSEE	35.0%	INTERTRI	7.0%
ALABAMA	18.0%	TEXAS	26.5%	CALIFORNIA	32.0%	ROSEBUD	6.0%
TEXAS	14.0%	CALIFORNIA	25.0%	TEXAS	30.4%	POTAWATO	4.3%
TENNESSEE	11.0%	ARKANSAS	25.0%	ALABAMA	30.0%	CHOCTAW	4.0%
IOWA	8.0%	TENNESSEE	25.0%	NEW JERSEY	26.4%	MAINE	3.7%
WYOMING	7.5%	NEW YORK	21.2%	NEVADA	25.0%	PUERTO R	3.0%
WISCONSIN	5.7%	PENNSYLVANIA	19.4%	MARYLAND	23.7%	UTAH	2.6%
KENTUCKY	4.4%	COLORADO	18.6%	MISSOURI	23.6%	WASHINGT	2.0%
FLORDIA	3.8%	MINNESOTA	18.4%	PENNSYLVANIA	23.0%	E CHEROK	2.0%
NORTH DAKOTA	3.7%	ILLINOIS	18.2%	ILLINOIS	22.8%	CHEYENNE	0.9%
MISSOURI	1.6%	KENTUCKY	18.2%	MINNESOTA	22.6%		
		NEW JERSEY	17.9%	NEW YORK	21.8%		
		MISSOURI	17.8%	MASSACHUSETTS	21.5%		
		N CAROLINA	17.3%	NAVAJO TRIBE	21.0%		
		WEST VIRGINIA	17.0%	N CAROLINA	20.5%		
		IOWA	16.0%	RHODE ISLAND	19.4%		
		NEW MEXICO	15.5%	IOWA	19.0%		
		NORTH DAKOTA	15.5%	ARKANSAS	19.0%		
		WISCONSIN	15.2%	KENTUCKY	18.7%		
		MONTANA	14.9%	COLORADO	18.4%		
		FLORDIA	13.7%	DELAWARE	18.0%		
		VIRGINIA	13.3%	NEW MEXICO	17.8%		
		SOUTH DAKOTA	11.1%	WEST VIRGINIA	17.0%		
		NEVADA	11.0%	WISCONSIN	16.6%		
		MASSACHUSETTS	11.0%	WASHINGTON	15.5%		
		WYOMING	9.6%	CONNECTICUT	15.4%		
		INDIANA	9.6%	MONTANA	15.1%		
		RHODE ISLAND	5.9%	NORTH DAKOTA	14.6%		
		CONNECTICUT	5.7%	ALASKA	12.0%		
		WASHINGTON	5.2%	FLORDIA	11.6%		
		MAINE	4.3%	NEW HAMPSHIRE	11.1%		
		NEW HAMPSHIRE	3.5%	S CAROLINA	10.9%		
		WASHINGTON, D.	1.6%	WYOMING	10.4%		
				ARIZONA	10.0%		
				INDIANA	9.8%		
				SOUTH DAKOTA	8.3%		
				HAWAII	8.0%		
				VIRGINIA	7.1%		
				OHIO	7.0%		

Cont.,top next column

NOTE: Differences in percentages between states are due to several factors, including the level of rebate received and the time of year contracts were signed.

PREPARED STATEMENT OF ROBERT GREENSTEIN

I appreciate the opportunity to testify before the Task Force today. I am Robert Greenstein, director of the Center on Budget and Policy Priorities. The Center is a non-profit research and analysis organization that specializes in public policy issues affecting low and moderate income Americans and that conducts a substantial amount of work on the WIC program. Accompanying me is Stefan Harvey, the director of the Supplemental Food Program project at the Center.

I. BACKGROUND ON THE WIC PROGRAM

Before discussing the funding problems currently facing the WIC program, I would like briefly to address several issues concerning the importance of WIC. As I believe the Task Force knows, WIC has been found to be one of the most effective of all federal social programs.

Numerous evaluations of WIC have found compelling evidence of the program's impact in improving the health of participating women, infants and children. WIC has been linked to reductions in the incidence of late fetal deaths, low birthweight, prematurity and anemia, and to improvements in the diets and nutritional status of its

clients. A multi-year medical evaluation supported by USDA and directed by Dr. David Rush, one of the nation's leading researchers in the field, found that:

- WIC participation contributed to a statistically significant decline of between 20 and 33-1/3 percent in the late fetal death rate.
- Women who participated in WIC had longer pregnancies leading to fewer premature births. In particular, there was a 23 percent decrease in prematurity among less educated white women with less than a high school education and a 15 percent decrease among black women with similar levels of education.
- WIC participation resulted in a significant increase in the number of women seeking prenatal care during the first trimester of pregnancy and a significant reduction in the proportion of women with inadequate numbers of prenatal visits.
- WIC significantly increased the head circumference of infants whose mothers received WIC during pregnancy. (Head size generally reflects brain growth.)
- Children enrolled in WIC were better immunized and were more likely to have a regular source of medical care.

Findings from the Rush study also indicate that participation in WIC may contribute to improved cognitive performance among children. Other studies have found that WIC results in reduced hospitalization costs and lowers Medicaid expenditures. In addition, research conducted by the National Bureau of Economic Research, the research center whose president is Martin Feldstein, found that WIC is the second most cost-effective program for reducing infant mortality in the United States. A synopsis of various findings from studies on the health impact of the WIC program is included in Attachment 1.

Despite this impressive track record, several million eligible low income pregnant and postpartum women, infants and children remain outside the program. WIC is not an entitlement program. Due to funding limitations, many low income, nutritionally-at-risk individuals can not be served. WIC reaches an estimated 50-65 percent of the eligible population nationally. In many states, the proportion of the eligible population that is served is considerably smaller than this.

During the past several years, WIC has expanded and reached more of the eligible population each year. This growth has occurred both because Congress has increased WIC funding levels and because infant formula cost containment systems implemented in recent years have saved millions of dollars which were then used for program expansion.

These cost containment savings are quite substantial. In the FY 1991 Budget Summary issued by the U.S. Department of Agriculture (a document released in conjunction with the Administration's FY budget), the Department estimated total WIC cost containment savings for fiscal year 1990 at $450 million. USDA projected that these savings would enable WIC to serve 820,000 more participants this fiscal year than would have been served if there were no cost containment savings at all.

II. THE WIC FUNDING CRUNCH

The WIC program now faces a serious funding crunch. Primarily because dairy and orange juice prices rose far more than had been predicted this year, many states now find themselves forced to institute significant cutbacks in their WIC programs.

The best information on the nature and extent of these cutbacks comes from two surveys conducted in the first half of June, one by the National Association of WIC Directors (NAWD) and one by USDA. In most cases, the state data collected in these two surveys are similar. In those instances where the two surveys differ, our Center contacted states between June 20 and 25 to resolve the discrepancies and obtain the most up-to-date information. The findings are as follows.

The Survey Findings

The most striking finding that emerges from the survey data is that the WIC cutbacks are wider and deeper than had previously been realized.

- Both the USDA and NAWD surveys show at least 25 states cutting WIC participation (although there are some differences between the two surveys in the specific states listed).
- The NAWD survey shows that between March and September, some 25 states will cut their caseloads by 242,000 participants.
- The data in the USDA survey show that 26 states are instituting cutbacks, with these states reducing their caseloads by 239,000 participants during this period.
- The USDA survey also shows that at least six states are cutting back on the food provided to participants in the program. In most cases, the states cutting back on the food are states that are also reducing their caseloads. However, at least one state is maintaining its caseload but reducing the food package.
- The caseload reductions are particularly large in some states, as is reflected in the table on page 6.

The NAWD survey notes it reflects data through June 10 and forecasts that "as states continue to update participation and fiscal reports, the number [of participants

being cut from the program] will increase." The NAWD survey also notes that 41 states now restrict WIC participation to certain priority categories of eligible persons, with eligible persons in other categories automatically denied entry into the program.

Survey Update

Because the two surveys contain significantly different information for several states, the Center on Budget and Policy Priorities contacted these states during June 20-25. The Center asked the states to resolve the discrepancies between the two surveys and to provide the latest available information on these issues. When the NAWD and USDA surveys are supplemented by the updated information obtained in this manner, the following results are found:

- The number of states reducing their WIC caseloads is now at least 27.
- The total number of participants being cut from the program in these states is approximately 280,000.

The revised totals are higher than the totals in either of the original surveys because each survey picked up some state cutbacks that the other survey had missed, and because estimates of the size of the cutbacks have risen in a few states since these surveys were conducted.

The Presentation of the USDA Survey Data

While the NAWD and USDA data complement each other, the texts of the surveys are quite different in their tone. The USDA document presents a rather

Projected Caseload Cutbacks -- March - September[1]

State	Cutback, NAWD Survey	Cutback, USDA Survey	Best Cutback Assessment In Cases Where Surveys Differ Significantly[2]
Alaska	2,500	____	
Arizona	3,000	3,304	
California	36,000	56,273	53,000
Colorado	10,000	9,482	
Connecticut	4,000	3,552	
Florida	25,000	23,102	25,600
Georgia	17,000	20,480	
Hawaii	1,000	967	
Iowa	4,000	3,792	
Kansas	____	921	836
Kentucky	____	2,741	2,996
Maine	1,062	____	1,062
Minnesota	____	2,951	2,951
Missouri	14,000	8,344	14,000
Nevada	500	524	
New Hampshire	1,274	5,878	5,878
New York	31,000	____	31,000
North Carolina	10,000	11,689	
North Dakota	800	863	
Ohio	2,659	2,659	
Oklahoma	15,600	15,544	
Oregon	2,000	____	2,000
Puerto Rico	16,000	19,269	
Rhode Island	509	509	
Texas	27,000	16,986	27,000
Utah	12,000	21,423	20,463
Virginia	____	1,801	0
West Virginia	2,096	2,103	
Wisconsin	____	2,697	0
Wyoming	1,400	1,369	
Indian agencies[3]	1,849	____	1,849
TOTALS	242,249	239,223	

Note: Footnotes appear at end of testimony.

soothing picture that downplays the problems states are now facing. The USDA text states:

> "Participation in the program reached an all-time high in March. While some states will experience declines from these participation levels, as many as 20 states will maintain or increase participation from March through the end of Fiscal Year 1990. (See enclosed tables.) Additionally, another 5-10 states, including Illinois, Ohio, and Pennsylvania, will experience little if any participation decline from March levels."

However, according to the Department's own survey data, 26 states are cutting caseloads by at least 500 participants and the average caseload cutback in these states is 9,200 participants.

The USDA memo also states that March -- the month from which the cutback levels are measured -- "represented an all-time high" in terms of WIC participation. The March participation level cannot be considered to represent an inordinately high participation level, however. Some 4.63 million people received WIC benefits in March. This number is identical to the average participation level that USDA projected for FY 1990 in budget documents issued in late January with the release of the FY 1991 budget.

Finally, while a modest number of states are still increasing their caseloads, the increases tend to be small and to offset only a small fraction of the caseload reductions in other states. Overall national participation is expected to be substantially lower in September than it was in March.

Hard Hit States

Ten states are reducing caseloads between March and September by 10 percent or more. These states are: California, Colorado, Florida, Georgia, Missouri, New Hampshire, Oklahoma, Puerto Rico, Utah, and Wyoming. Oklahoma is suffering not only from the effects of higher food prices, but also from sharp reductions in the rebate levels being received under its new infant formula cost containment contract, which took effect May 1, 1990.

State	Percentage Caseload Reduction Between March and September*
California	11%
Colorado	19%
Florida	13%
Georgia	12%
Missouri	15%
New Hampshire	36%
Oklahoma	28%
Puerto Rico	14%
Utah	45%
Wyoming	15%

* Based on USDA data on March participation levels and data from USDA survey on September participation levels, except in states where more current data were subsequently provided to the Center.

III. WHY HAS THIS OCCURRED

The principal reason these cutbacks are occurring is that WIC food prices have risen much more rapidly in FY 1990 than had been predicted. In issuing WIC

allocations for federal fiscal year 1990, the U.S. Department of Agriculture assumed that WIC food prices would rise 4.5 percent this year. Most states planned accordingly. Unfortunately, however, this estimate has proved much too low.

During the first six months of the fiscal year, WIC food prices soared, propelled by the steepest increases in milk prices in more than ten years and sharp increases in fruit juice costs in the aftermath of the December freeze. WIC food prices in some states rose at an average rate of as much as one percent per month during this period.

Dairy Prices

- From September through January, milk prices rose at a tremendous clip. The Consumer Price Index for fresh whole milk rose 1.7 percent in September, 1.5 in October, 2.4 percent in November, 3.6 percent in December, and 3.1 percent in January. It also rose 0.9 percent in February, a lesser but still substantial increase.

- The wave of rapid milk price increases now appears to be over as milk prices edged down 0.3 percent in March and then declined an additional 1.6 percent in April and 0.9 percent in May. However, milk prices in May 1990 were still nearly 11 percent above the May 1989 level.

- Cheese prices have followed a generally similar pattern during this period, rising sharply through February, flattening out in March, and declining 1.5 percent in April. However, while milk prices dropped in May, cheese prices climbed 0.6 percent. Cheese prices in May 1990 were 12.8 percent above their May 1989 level.

Juice Prices

- Juice prices have also risen rapidly in recent months, largely as a result of low production in the aftermath of the severe freeze in December. The Consumer Price Index for fruit juices and frozen fruit jumped 6.8 percent in February and another 4.5 percent in March. It then rose an additional 1.4 percent in April, and a further 1.1 percent in May.

- In May 1990, this index was 13.8 percent higher than it had been in May 1989.

These data on milk, cheese, and juice prices are quite significant. These products account for about half of the cost of the WIC food package.

Price Increases

	May 1989 - May 1990
Fresh whole milk	+10.7%
Cheese	+12.7%
Fruit juices and frozen fruit	+13.8%

A Second Phase to the Cutbacks: Is the Worst Still to Come?

Unfortunately, a second set of developments may pose an even more serious threat to the WIC program than the sharp food price increases experienced this year. In recent months, the nation's largest infant formula companies have instituted new strategies to reduce the savings that states have been achieving through WIC infant formula cost containment systems.

At the beginning of 1990, nearly every state had a cost containment system in place to reduce the cost of infant formula sold through the WIC program. An average of about $1.25 per can of formula was being saved. As noted, USDA forecast back in January that some $450 million would be saved in FY 1990 as a result of these cost

containment systems -- and that these savings would enable 820,000 more participants to be served than could be served in the absence of cost containment.

Beginning in March 1990, however, the infant formula companies began to scale back the price reductions (or rebates) being offered to most state WIC programs. There has been noticeable similarity between the lowered rebate bids submitted by the major manufacturers. The companies are now offering rebates of just 70 to 80 cents per can of infant formula to most of those states seeking bids for new cost containment contracts. (These states must seek new bids and enter into new contracts because their existing contracts are expiring.) States that experience significant declines in the rebate levels they receive generally have no alternative but to institute program cutbacks, unless increased WIC appropriations can offset the loss of rebate funds.

By the end of FY 1991, more than half of the states will face this problem, since their existing cost containment contracts will expire. If the pattern that has held since March 1990 continues indefinitely and eventually affects all states as their current contracts expire, some $100 million to $200 million a year in cost containment savings will eventually disappear -- and several hundred thousand fewer women, infants, and children will be served through WIC.

To date, the cutbacks from the loss of these rebate funds have taken effect in only a few states, such as Oklahoma. Several of those states that recently solicited bids for new contracts -- and received offers for much lower rebate levels than they have been getting -- do not institute their new contracts until July or October. In addition, a much larger number of state contracts do not expire until FY 1991.

This means that the WIC cutbacks currently occurring due to increased dairy and orange juice costs are likely to be simply *the first stage of cutbacks*. Larger cutbacks are likely to follow in many states as infant formula rebates decline.

It should be noted that on May 29, the Senate Antitrust Subcommittee held a hearing to examine the recent pattern of activity in which the three major infant formula companies have all lowered their WIC rebate bids to similar levels. The hearing also focused on infant formula industry pricing patterns in general. At the hearing, the Federal Trade Commission announced it regarded these issues as sufficiently serious to launch an inquiry into them.

FTC investigations take time, however, and any remedial action the FTC may ultimately seek is likely to be subject to a lengthy court challenge. As a result, while the FTC involvement is very welcome, it does not offer much hope for relief from these ominous developments in FY 1991.

New Recommendations Call for Pregnant Women to Gain More Weight

A final point that should be noted is that the current cutbacks, which include reductions in some states in the amount of WIC food provided, come at a time when medical experts are recommending that pregnant women gain more weight, not less. A new study prepared by the Institute of Medicine of the National Academy of Sciences recommends that pregnant women gain about 10 pounds more than had previously been recommended. The Institute's panel of medical experts concluded that more weight gain is needed to reduce the incidence of babies born with a low birthweight.

Reductions in WIC foods provided to pregnant women and cutbacks in WIC caseloads are likely to make this goal harder to achieve.

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1. The NAWD survey was conducted June 4-8. The USDA survey was conducted June 1-13. Not all states responded to the NAWD survey USDA collected data for all states.

2. The figures in this column reflect information provided by states when contacted during June 20-25 by staff of the Center on Budget and Policy Priorities. In contacting these states, two common problems with the NAWD and USDA survey data came to light. First, not all states responded to the NAWD survey. As a result, several states that reported cutbacks to USDA were not listed in the NAWD survey. Second, a problem identified in the USDA survey is that for at least two states (New York and Texas), the number of participants projected for September includes both participants supported with federal funds and participants supported with state funds -- while the number report for March includes only participants supported with federal funds.

   In several states, estimates of the number of participants that will have to be cut have grown since the NAWD and USDA were conducted earlier in June. in a few states, the situation has improved. Two states that were planning cuts earlier in the month, Virginia and Wisconsin, no longer plan to institute such measures.

3. The Indian state agencies which the NAWD survey lists as reducing caseload, and the number of their reductions, are: Choctaw (OK) (750), Chickasaw (492), Potawatomi (234), Isleta Pueblo (100), Choctaw (MS) (100), Pueblo San Felipe (52), Cherokee (NC) (50), Pueblo Zuni (41), Santo Domingo (30).

PREPARED STATEMENT OF DR. DAVID M. PAIGE

Congresswoman Boxer, members of the Committee, I am Dr. David M. Paige, Professor of Maternal and Child Health at the Johns Hopkins University School of Hygiene and Public Health with a Joint Appointment in Pediatrics at the Johns Hopkins School of Medicine, and attending Pediatrician at the Johns Hopkins Hospital. I am Chairman of the Maryland State Advisory Council on Nutrition and a member of the State WIC Advisory Panel. I appreciate the opportunity of appearing before the Committee this morning.

I wish to report on the health benefits, both preventive and remedial, of the U.S. Department of Agriculture WIC Program.

Maternal Nutrition

Maternal nutrition, birthweight, and infant survival are inexorably linked. The nutritional status of women is therefore important in influencing the course of the pregnancy. This is particularly true of low-income, high-risk women. Differential patterns continue to exist in pregnancy outcome between high and low socio-economic groups. Approximately 7% of all U.S. births are LBW, with the incidence of LBW in poor white and black infants particularly high at 12.4%, and in advantaged white infants at 5.6%. In addition, almost 17% of black infants are premature, born before 37 weeks of gestation. The incidence of prematurity is more than twice as likely to occur to a mother who is young, poorly educated, with a short pregnancy interval, and not effectively utilizing prenatal services. In the absence of prenatal care the precentage of premature infants born to black women climbs to 31.2%, and for white women the figure is 22%.

In 1987, approximately, 250,000 LBW infants were born in the United States. In that same year, over 28,000 infants less than 28 days of age died. The majority of these deaths, as well as those neonates requiring extended hospitalization resulted from LBW as a consequence of poor fetal growth.

WIC Impact on Pregnancy Outcome

Significant improvement in birthweight and a reduction in the number of low birthweight infants have been reported when nutritional supplements such as those distributed through the U.S.D.A. WIC Program are provided. Data from the National WIC study, indicates that there is a large reduction in premature births, as well as infants of low birthweight born to high-risk white and black women. The estimated reduction is 23% among white women and 15% among black women. There is also a corresponding increase in birthweight.

This outcome is consistent with the fact that women initially enrolled in the WIC program reported consuming 111 calories more than control women. More than half the incremental calories were supplied by dairy foods, and smaller, equal, amounts from juices and cereals. Further, women enrolled in the WIC program also reported a significantly greater intake of 14 nutrients: protein, calcium, iron, magnesium, phosphorus, thiamin, riboflavin, niacin, Vitamin B6, Vitamin B12, and Vitamin C. The WIC program thus achieved significantly increased intakes of four of the five major nutrients initially specified as target nutrients: protein, iron, calcium, and Vitamin C.

GAO Report

The data is consistent with the General Accounting Office Report which concludes, that the percentage of WIC mothers with LBW infants was 7.9% compared to 9.5% in non-WIC mothers. This decrease of approximately 1.6% will result ina 20% decrease in the projected number of LBW infants. The projected reduction will result in 49,620 fewer LBW infants being born, approximately, 5,000 fewer neonatal deaths, and an estimated savings of hundreds of millions of dollars in extended hospital care costs for a majority of the survivors. This figure is based on the 1985 Institute of Medicine report citing an average approximate hospital cost of $20,000 for a LBW infant in Michigan, where the study was done, and as much as $62,000 on an average for LBW infants born at less than 35 weeks gestation.

In addition, the GAO report indicates there is a significant increase in mean birthweight in the women who are on WIC. Further, these benefits appear to be differentially associated with the highrest risk women. In fact, those women who are teenagers, those of minorities, those who are least educated, those with the shortest pregnancy intervals show the greatest effect.

Medical Health Costs

An analysis of the Missouri Medicaid records with corresponding birth records for non-WIC and WIC participants to compare pregnancy outcomes and Medicaid costs for newborns; revealed, that WIC participation was associated with a reduction in Medicaid newborn costs of about $100 per participant. Further, Schramm estimated that for every dollar spent on WIC, about $0.83 in Medicaid costs were saved. Further, in a 1986 study, Schramm examined whether the Medicaid cost savings, relative to the non-WIC group, increased along with participant duration in WIC. He estimated a $107 Medicaid savings for those participants with the longest duration in the program.

Food Package

Distorting the food package by eliminating essential foods for pregnant and lactating women to solve the budgetary crisis will defeat the preventive and remedial elements of the WIC Program. The need for a robust weight gain during pregnancy and its association with an improved outcome of pregnancy is well recognized and is most recently underscored by the National Academy of Sciences recommendation that pregnant women gain more weight. Reducing the amount of food provided in the WIC package will impede many of the highest risk women from meeting this standard.

Preschool Period

Preschoolers are going through a period of rapid growth and intellectual and social development. Poor nutritional status can lead to increased illness and decreased ability to learn. WIC has been shown to significantly improve the nutrient intake of preschool children.

The most common problem, at this age in the WIC-eligible population, is iron-deficiency anemia. This is particularly common in late infancy and early childhood. Iron deficiency is the end result of a continuing imbalance between the child's intake and need. Iron deficiency is associated with growth spurts -- most strikingly in the period from six to eighteen months. The WIC program has had a major impact on the intake of iron in high risk low income children. The National WIC Evaluation reports that infants, and preschool children ingest 33% and 15% more iron respectively than control children. According to the Centers for Disease Control, WIC has contributed to the decrease in iron deficiency anemia among low-income preschoolers between 1975 and 1985.

Cognitive Development

It is important to note, that Iron, along with other nutrient deficiences, may also play a role in influencing intellectual development. Specifically, iron deficient infants have lower mental development scores than those with adequate iron. Iron deficiency can also be associated with deficits in attention and new-concept learning among preschool children, and with lower educational achievement test scores among school children.

The National WIC Evaluation also reported, improved cognitive development in children. The vocabulary scores were significantly greater in WIC children whose WIC benefits began in utero, than controls. ~~among children~~. Digit memory was also significantly greater in WIC chidlren than controls.

The Need for Continued WIC Enrollment

Studies in developing countries have generally shown short-term effects of food or nutritional supplementation during pregnancy and infancy. But these effects have almost invariably "washed out by the time the children reach school age.

The WIC program addresses this potential limitation by providing food supplements throughout the preschool period. WIC professionals have a unique opportunity to both improve and maintain the nutritional status of low-income populations at greatest nutritional risk. Nutrition education to prevent nutritional problems, coupled with supplementation with proper foods for nutritional remediation and maintenance, is a powerful public health tool. To limit and/or reduce WIC enrollment, given the agreed upon health benefits to the women, infant, and children, the program serves is both inequitable and medically inappropriate.

Attachment.

Volume 5, Number 5 September/October 1986

Clinical Nutrition

Fetal Growth, Maternal Nutrition, and Dietary Supplementation

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Maternal nutrition, birthweight, and infant survival are inexorably linked. While many factors influence pregnancy outcome, prepregnancy weight, maternal weight gain, fat deposition, and placental growth are critical elements influencing fetal development. The nutritional status of women is therefore important in influencing the course of the pregnancy. This is particularly true of low-income, high-risk women. Significant improvement in birthweight and a reduction in the number of low birthweight infants have been reported when nutritional supplements such as those distributed through the U.S.D.A. WIC (Supplemental Food Program for Woman, Infants and Children) have been provided to high-risk women. (CLIN NUTR 1986;5:191-9)

FETAL GROWTH

The significance of birthweight and its influence on infant survival has been of concern through the centuries. Although the earliest references to the practice of weighing infants at birth dates from Biblical times, the potential importance of birthweight does not appear to have been recognized until the end of the seventeenth century, when it was reviewed by the French obstetrician Mauriceau. However, Mauriceau's widely cited measurements were nevertheless incorrect; his estimate of a normal birthweight was about 15 pounds. An accurate assessment of normal birthweight did not enter the English-language literature until late in the eighteenth century. Yet infants at birth showed sufficient differences in birthweights to support the concept that weight could be used to assess nutritional status and physical growth.[1]

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In the early 1900s, clinicians began to assess the relationships among inadequate low birthweight, prematurity, and mortality. In 1930, a Finnish pediatrician, Yllpo, suggested 2500 grams as the birthweight below which infants were at high risk of adverse neonatal outcome.[2] This threshold weight was adopted by the World Health Organization as an appropriate standard. In 1948, the First World Health Assembly agreed on the following definition: "For the purpose of this classification, an immature infant is a liveborn infant with a birthweight of 5½ pounds (2500 grams) or less, or specified as immature."[3] In 1950, the WHO Expert Group on prematurity reinforced the use of the 2500 gram.[4] Further clarification of the definitions by the 1961 WHO Expert Committee on Maternal and Child Health resulted in the following recommendation: the word "premature" be reserved for infants born before 37 weeks from the first day of the last menstrual period.[5]

It is now recognized that further attention to differences in timing between peak-length velocity and peak-weight velocity of the fetus will permit additional distinctions to be made regarding fetal growth. Peak-length velocity occurs around the 20th week, whereas peak-weight velocity occurs at about 33 weeks of pregnancy. By the 28th week, length has reached 71% of the mean length at term, whereas weight is only 32% of the full-term infant weight.[6] Thus, the timing, intensity, and duration of the negative factors affecting fetal growth will manifest themselves in differing patterns.

When interference with growth occurs throughout the pregnancy there is a balanced reduction in the length, as well as in the weight of the fetus. This is referred to as "proportionate IUGR" (intrauterine growth retardation). Alternatively, if interference with fetal growth occurs later in the pregnancy when body length is almost completed only weight will be reduced. This is referred to as "disproportionate IUGR."[7] A third group has been suggested, con-

sisting of those fetuses who underwent normal growth but were negatively affected in the last 2 to 3 weeks of gestation, when both length and weight growth were almost completed. In the absence of adequate supplies, this group had to use their own fat stores and thus lost weight.[9] Skinfold measurements taken at birth may differentiate these last two groups. The latter should have very low fat but relatively normal muscular mass, whereas the former should show reductions in both muscle and fat.

MATERNAL NUTRITION

Prepregnancy Weight

Nutritional factors both before and during pregnancy clearly influence fetal weight gain and pregnancy outcome. Low prepregnancy weight has been identified as a factor influencing maternal health and fetal growth. It is defined as a weight of less than 47 kg or 20% or more below the standard for height and age. Low pregnancy weight ranks behind subnormal cumulative weight gain during pregnancy as a determinant of low birthweight.[9] Low prepregnancy weight may reflect increased lean body mass and minimal fat deposit. This limited storage of fat, coupled with diminished fat deposit during pregnancy because of low weight gain, may influence the growth of the fetus.[10] In addition, pregnant women at low weight have been reported at increased risk for eclampsia, preeclampsia, premature labor, and antepartum hemorrhage.[9]

Maternal Weight Gain

Inadequate weight gain during pregnancy is usually considered as a gain of 1 kg or less per month in the second and third trimesters. This inadequate weight gain has been associated with a lower birthweight and a higher risk of maternal complications.[9] Excessive weight gain is considered to be on the average of a gain of 3 kg or more per month in the second and third trimesters.

Maternal weight gain is accounted for by the fetus, the placenta, and the woman's compensatory changes for pregnancy and lactation. The weight gain in the first trimester is usually minimal (about 1 kg). After the 9th week there seems to be a linear increase of 0.3 kg to 0.4 kg per week until term.[9] The most rapid weight gain takes place in the latter part of pregnancy.[14] As noted earlier peak linear growth of the fetus has occurred before this period, with peak velocity occurring in midpregnancy.[16] In the second trimester the weight gain is predominantly in the maternal compartment, with expansion of the blood volume, uterine and breast hypertrophy, and accumulation of adipose tissue. The gain is primarily in the products of conception (the placenta, fetus, and amniotic fluid) in the third trimester.[9]

Maternal nutrition, birthweight, and infant survival are inexorably linked.

The earlier research work of Hytten, Niswander, Leitch, and others[11-16] on the subject of weight gain in pregnancy served to bring about a greater appreciation of the importance of adequate weight gain in pregnancy. Earlier, obstetricians made an effort to limit the weight gain in pregnancy. Patients are now encouraged to gain an average 28 to 30 pounds during pregnancy.[17]

Recent studies examining the influence of weight gain during pregnancy on duration of gestation and infant size at birth underscores the importance of maternal weight gain.[18] Six hundred fifty-four prenatal patients were categorized as women beginning pregnancy underweight, moderately underweight, or of normal weight. Underweight women were 80% of standard weight, as previously defined, moderately underweight women were between 80% and 90% of standard, and normal weight women were between 90% and 120% of standard weight. The Metropolitan Life Insurance Tables were used to calculate standard weights. Results indicate that (1) prepregnancy weight status was not associated with the amount of weight gain during pregnancy, (2) the underweight women who gained the same amount of weight as the normal weight women delivered infants at a younger gestational age and of lower birthweight and length, and (3) more than half of the infants born to the underweight women, failing to gain 9 kg during pregnancy, weighed less than 2501 g[18] (Table I). The results of this study suggest that weight gain during pregnancy be considered on the basis of the prepregnancy status, and that an adequate weight gain during pregnancy is of critical importance to those women who began their pregnancy underweight.[18]

Abrams and Laros,[19] reporting from California, on the effect of maternal weight gain on birthweight in 2946 live births after 37 weeks gestation indicate also, both pregravid body mass and weight gain significantly influence birth weight. The authors note that each kilogram of maternal weight gain significantly increased birthweight. This is true for underweight, ideal weight, and moderately overweight women. The positive association is limited to prepregnancy weight of 135% of ideal or less (Fig. 1). These studies underscore earlier reports of the positive influence of prepregnancy and weight gain during pregnancy on birth weight.[11-13,20-22] Risk may be the highest within subgroups, such as adolescents.[23]

Components of Maternal Weight Gain

As a result of the above information, weight gain during pregnancy has been used as an index of adequate maternal nutrition. The total dietary energy need for pregnancy has been calculated to be 85,000 kcal or about 300 additional kcal per day if the need is equally distributed over the 280 days of pregnancy.[24] About 41,000 kcal represent the energy equivalent of protein and fat deposited in newly synthesized tissue. An additional 36,000 kcal is needed for metabolism of newly acquired fetal and maternal tissue, and 8000 kcal is needed for converting dietary energy to tissue or metabolizable energy.[25]

Weight gain is divided between the mother and the fetus, with maternal gain primarily occurring during the second and third quarters of pregnancy and fetal tissue gain occurring primarily in the fourth quarter. The maternal gain

is mostly fat and has a higher energy equivalent (9.5 kcal/g) than fetal tissue (6.5 kcal/g). Therefore, energy needs are greater during the second and third quarters (about 400 kcal/day) than during the fourth quarter (about 300 kcal/day). The overall effect of this method is to divide the additional energy cost over three quarters of the pregnancy instead of having a large demand during the final weeks. Distributing the total energy need over the entirety of pregnancy seems valid when considering recommendations for the pregnant population.[24,25] It is therefore the total requirement that underpins the recommendation of an additional 300 kcal daily for pregnant women.[19,25]

Maternal Fat Stores

An important component of maternal weight gain is maternal fat stores. These stores may provide an energy reserve for fetal growth. The 4 kg of fat deposited during the pregnancy is capable of providing approximately 35,000 kcal. This energy reserve is sufficient to sustain fetal growth in the last trimester of pregnancy. More than 40% of the maximum energy required for the pregnancy can be found in the fat deposited as maternal stores in healthy women during the earlier part of the pregnancy. In western societies energy requirements may in practice be lower because of increased pregnancy-specific requirements being offset in part by reduced energy expenditure on activity. Fat stores not used during pregnancy are available as an energy source during lactation. It is suggested that progesterone may be the stimulus for fat storage. The mechanism of action may be by influencing hypothalamic control of fat deposition. The fat deposited during pregnancy may not be as critical in contemporary modern societies as it was throughout the centuries with unpredictable food supply and availability. It may still be important to women whose caloric intake during pregnancy is reduced because of environmental, social, and psychological reasons.[19]

On the other hand, obese women, with a weight of 20% or more above the standard, have ample fat stores. They presumably could support the energy requirements for pregnancy without depositing additional fat.[25] Reanalysis of the data from the United States Perinatal Collaborative Study, however, indicates that less-than-optimal weight gains in obese women are associated with lower perinatal mortality rates. Obese women who gained approximately 16 pounds had a perinatal mortality rate of 30.8 deaths/1000 births. Those who gained 27 pounds had a perinatal mortality rate of 35.0/1000 births. In this study less-than-optimal weight gains were more common among the obese women than among the normally proportioned women.[25,27,28] A different standard of weight gain may be needed for obese pregnant women. More studies are needed to validate these findings.

The impact of heavy physical activity on energy needs during pregnancy must also be considered. Limited evidence suggests that physically active pregnant women have a greater energy re-

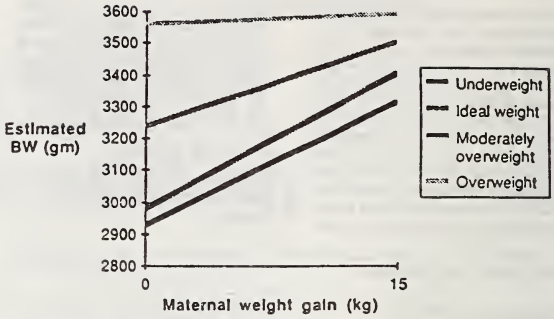

Fig. 1. Birthweight of 2946 infants at term by prepregnancy weight category and weight gain adjusted for gestational age, maternal age, race, parity, SES, and cigarette consumption. (Reproduced with permission from Abrams BF, Laros RD. Prepregnancy weight, weight gain, and birth weight. Am J Obstet Gynecol. 1986;154:503-9.

Table I. Influence of prepregnancy weight status on weight gain during pregnancy, gestational age, and birth weight of infants

Prepregnancy weight status	N	Weight gain (kg)	Gestation (wk)	Birthweight (g)	Percentage of low birthweight (<2501 g)
Very underweight	155	12.6 ± 0.27	38.9 ± 0.3	2976 ± 48	12.9 (N = 20)
Moderately underweight	243	12.9 ± 0.32	38.9 ± 0.2	3020 ± 41	16.5 (N = 40)
Normal weight	247	12.6 ± 0.5	39.5 ± 0.1	3234 ± 32	6.9 (N = 17)
Significance level*		NS	$p<0.032$	$p<0.0001$	$p<0.0005$

Results are reported as mean ± SE.

* Differences between mean values obtained for normal weight and underweight women.

Reprinted with permission from The American College of Obstetrics and Gynecologists.[19]

The total dietary energy need for pregnancy has been calculated to be 85,000 kcal or about 300 additional kcal per day if the need is equally distributed over the 280 days of pregnancy.

Table II. A comparison of infant and placental size in AGA and SGA infants at term (mean ± SD)

	AGA	SGA	t
Number	40	40	
Gestational age (wk)	39.2 ± 1.3	39.2 ± 1.2	
Birthweight (g)	2940 ± 282	2162 ± 321	11.5†
Head circumference (cm)	34.1 ± 1.1	32.1 ± 1.3	7.4†
Crown-heel length (cm)	48.5 ± 1.7	45.1 ± 2.0	8.2†
Placental weight (g)	424.8 ± 56.6	295.8 ± 53.5	10.5†
Chorionic plate area (cm^2)	252.2 ± 39.6	191.6 ± 40.4	6.8†
Placental weight/birthweight	0.1442 ± 0.185	0.137 ± 0.225	1.6*
Placental weight/head circumference	12.29 ± 1.81	9.17 ± 1.69	8.0†
Placental weight/crown-heel length	8.82 ± 1.44	6.50 ± 1.13	8.0†

* $p>0.05$.

† $p<0.001$.[29]

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Table III. A comparison of gestational age, head size, and placental size in AGA and SGA infants at term (mean ± SD)

	AGA	SGA	t
Number	10	10	
Gestational age (wk)	39.3 ± 1.0	39.2 ± 1.1	0.2*
Head circumference (cm)	34.0 ± 0.8	32.2 ± 0.9	4.9†
Assessed brainweight (kg)	0.348 ± 0.028	0.288 ± 0.027	4.9†
Placental weight (g)	457.0 ± 70.0	304.3 ± 41.7	5.9†
Villous surface area (m^2)	14.77 ± 2.4	8.28 ± 1.42	7.4†
Placental weight/assessed brain weight	1324 ± 244	1064 ± 163	2.8‡
Villous surface area/assessed brain weight	42.67 ± 7.12	29.00 ± 5.83	4.7†

* $p>0.05$.

† $p<0.001$.

‡ $p<0.02$.[29]

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quirement than sedentary pregnant women.[25,29] Pregnancy does not seem to cause a reduction in pace or an increase in the efficiency of energy use. Since body mass is increased, physically active women will need more energy to move their heavier bodies.[25]

Placenta

In addition to the effect of prepregnancy weight and maternal weight gain, the placenta plays a central role in influencing fetal growth and is, in turn, influenced by maternal nutrition. The placenta presents a complex interface between the fetus and mother that functions simultaneously to provide for active transfer (amino acids), carrier-mediated transport (glucose), diffusion (urea), and diffusion barriers (protein hormones) between mother and fetus. It is through this process that a continuous exchange occurs by which substrates for fetal metabolism and growth flow toward the fetus, while waste products pass from the fetus to the mother for excretion.[30]

Placental Growth

By the first trimester, the human placenta has reached a mature state; however, placental size and the number of functions continue to increase with fetal growth and development. Trophoblastic surface area and diffusion capacity are directly correlated with fetal weight and increase accordingly. Uterine blood flow increase is also noted. This corresponds to the increase in umbilical blood flow and fetal age. The placenta exhibits a long period of hyperplasia lasting through the 34th and 36th week of gestation; when cell division ends, the placenta continues to sustain some growth in size.

As a consequence of all these growth changes, there is a progressive increase of the villous or exchange surface area that reaches 11.0 ± 3 m^2 at 40 weeks. As a complement, there is a successive reduction in the thickness of the placental membrane, which will allow an increase in transport capacity of the placenta by the third trimester, which is a period of rapid fetal weight gain.[10,31]

Women living under poverty conditions have a lower mean placental weight than well-nourished women. Maternal studies suggest a nutritional role in placental growth.[32,33] An examination of placentas from malnourished Guatemalan women found that there were significant differences when compared with well-nourished Boston women. The peripheral villi and capillary absorptive surface were decreased in the placentas of the malnourished women, which suggest a reduced area for maternal-fetal exchanges. Additional comparative studies of Guatemalan women to women from Louisiana and Iowa indicate that the terminal villi of the placentas from Guatemalan women were significantly smaller than those from women from the United States.[33]

Placentas from malnourished women also have moderate reductions in DNA content and protein/DNA ratio. Considering the reduction in DNA content to be proportionally larger than the reductions in protein/DNA ratios, it is suggested that the phase of hyperplastic growth of the placenta to be proportionally more affected than the hypertrophic growth.[32,34-36] In view of the data it is possible that undernutrition may play an important role in influencing placental size and function, and the changes in the placenta may be important in determining fetal development, as well as subsequent infant and child development.[37]

A recent review documents the difference in the relationship between placental size in 40 SGA infants at term compared with 40 AGA infants at term. The ratio of placental weight to birth weight, head circumference, and crown-to-heel length were calculated for each infant. The mean birth weight, head circumference, crown-to-heel length,

placental birth weight, and chorionic plate area of the SGA infants were significantly less ($p<0.001$). Placentas from a subgroup of 10 infants in each of the two groups were studied in detail. Placental weight and villous surface area of the SGA infants were significantly less than those of the AGA group ($p<0.001$). The ratio of placental weight to assessed brain weight was significantly reduced in the SGA infants ($p<0.02$), as was the ratio of villous surface area to assessed brain weight ($p<0.001$). These findings suggest that the placentas of these small infants born at term are not only light in weight, as are the babies, but may be functionally defective for the delivery of calories from maternal to fetal circulations[38,39] (Tables II and III).

Maternal studies suggest a nutritional role in placental growth.

It is important to note that in undernourished women placental weight is proportionately more affected than fetal weight. In contrast, intrauterine growth retardation caused by factors other than nutrition (smoking, altitude) result in relatively larger placentas compared with fetal weight or high placental ratio.[16] This report suggests that whereas malnutrition may affect fetal growth through a reduction in placental size, factors affecting the fetus directly (tobacco) can stimulate a partial placental functional compensation.[40]

Little however is known about the effects of maternal malnutrition on the placental functions. Also, no attempts have been made to assess placental transfer functions in malnourished women because of ethical and technical limitations. Therefore, data that is available was derived from animal models.[41] Measurement of cardiac output and organ blood flow using radioactive microspheres in anesthetized control and food-restricted rats have demonstrated that malnourished mothers do not expand cardiac output and placental blood flow to the same extent as well-fed mothers.[41] However, they maintain normal blood flow to the myometrium and to vital organs. Thus, the reduced rate of transfer of nutrients found in the malnourished mothers may reflect a reduced rate of placental blood flow. In turn, the placental blood flow and cardiac output of the malnourished pregnant rats is probably caused by an inadequate blood volume/plasma volume expansion, a key hemodynamic adjustment that allows the pregnant mother to expand blood flow to the pregnant uterus without reducing blood flow to vital organs.[42]

The studies performed in the rat provide a new perspective on the mechanisms of fetal growth retardation during a period of malnutrition. In contrast with previous assumptions, the growth retarding effect of energy-protein malnutrition on the placenta and the fetus does not seem to be a primary effect but rather a secondary one mediated by a reduced placental blood flow. This, in turn, would reflect the inability of the malnourished mother to make certain key physiologic adjustments. Still, it is conceivable that certain direct effects of a reduced availability of energy and essential amino acids may occur in both the placenta and the fetus. Further studies of the characteristics of the placenta and the fetus in cases of intrauterine growth retardation in malnourished and well-nourished women may help to elucidate this problem.[43]

All the evidence presented points to the conclusion that maternal nutrition affects fetal growth in ways other than a simple reduction in nutrient availability. Changes in blood flow and/or placental weight may also mediate the negative impact that poor maternal nutrition has on the fetus and eventually on the newborn infant. Moreover, changes in some specific nutrients, calcium, or fatty acids, for example, may reduce placental circulation in otherwise well-nourished pregnant women.

DIETARY SUPPLEMENTATION

The preceding data support the view that nutritional assessment and, when appropriate, intervention should be major components of high-quality prenatal care. The Institute of Medicine Report released in 1985 emphasizes the value of the Special Supplemental Food Program for Women, such as the United States Department of Agriculture Food Program (WIC).[43] This program demonstrates the influence of nutrition on birthweight. For pregnant women, WIC provides vouchers to purchase nutritious foods, provides education about nutrition, and close referral ties to prenatal services. About 500,000 women receive WIC services each year, representing about 15% of total United States births. Once these high-risk women enter the WIC program, more than 90% participate fully until they give birth.[44] Other WIC recipients include lactating women and infant and children up to 5 years of age.

Evaluation studies, despite methodologic flaws, show that prenatal participation in the WIC program is associated with improved pregnancy outcomes.[44-47] Kennedy et al.[46] reported a 33% decrease in low birthweight status among the babies of participating women in comparison with a control group; Kotelchuck et al.,[44] a 21% decrease, and Kotelchuck and Anderka,[45] a 22% decrease. Metcoff et al.[47] and Kotelchuck and Anderka[45] also reported significant decreases in the incidence of small-for-gestational-age babies born to women who were WIC participants.

Recently the United States General Accounting Office (GAO) critically reviewed the published literature on the subject, and noted that while the quality of the evidence regarding WIC Program effects is uneven, there is evidence of program benefit. There is an increase in mean birthweight and a decrease in the percentage of low birthweight infants.[48] In another review of WIC evaluation studies, Rush et al.[49] concluded: "The best estimates are that participation in the WIC Program does lead to increased mean birthweight, probably in the range of 20 to 60 grams, with greatest effects among those at highest risk of nutritional causes of low birthweight (women with low weight at conception, blacks, smokers, etc.). Rates of birthweight under 2500 grams appear to be lowered by about one percent, and possibly as much as two percent, from base rates of around six percent of white births, and 11 or 12 percent of black births. There is reasonably consistent evidence that much of this difference is mediated by increase duration of gestation, and not just accelerated fetal growth."

The results of WIC evaluation studies also seem to indicate that early and consistent participation in the program

Table IV. Summary of significant findings of the effects of WIC benefits on pregnancy from the 1986 report on the national WIC evaluation

Pregnancy
Initial low maternal weight gain brought to level of control women (Longitudinal study)
23 to 47 g higher birthweight (Historical study)
Longer duration of gestation (1.4 days: Historical study)
Less frequent preterm birth among less educated, and presently higher risk, women (Historical study)
Significantly greater head circumference: effect much greater than (minimal) effect on birthweight (Longitudinal study)
Birthweight significantly associated with quality of WIC programs (rated by State WIC Directors: Longitudinal study)
Lower late pregnancy fat stores (Longitudinal study)

Adapted from Rush[52]

during pregnancy is related to magnitude of benefit. Edozien, Switzer, and Bryan,[43] Kotelchuck et al.,[44] and Schram[51] all showed that the benefits of WIC accrue principally to prenatal participants of 7 or more months duration. In particular, large reductions in low birthweight incidence are noted for women participating in WIC more than two trimesters, even after controlling for possible confounding of gestational age and duration of participation. The GAO report cited earlier concludes that there is some evidence to suggest that participating in WIC for more than 6 months is associated with larger increases in birthweight and decreases in the proportion of low birthweight infants than shorter participation periods.[43]

All the evidence presented points to the conclusion that maternal nutrition affects fetal growth in ways other than a simple reduction in nutrient availability.

National WIC Evaluation

The 1986 report of the U.S.D.A. National WIC Evaluation, as carried out by Dr. David Rush, notes that the effects of supplementation on the duration of gestation and fetal growth were approached in two independent studies using very different methods.[52] In the Historical Study of Pregnancy Outcomes, the extent of WIC program service to eligible pregnant women was related to national perinatal outcomes for over 11 million births in 1321 United States counties over 9 years. In the Longitudinal Study of Pregnant Women, WIC program enrollment, as well as detailed measurements of maternal social status and change in health and nutritional status, were related to pregnancy outcome for over 4000 women for whom hospital delivery and newborn records could be abstracted.

The Summary Report states that in the Historical Study of Pregnancy Outcomes, an increase in mean birthweight of 23 grams was estimated for women enrolled in the WIC program. This was significant and was in the range of what had been predicted as a likely effect of the program. Among less educated white women, the birthweight increase associated with WIC was 47 grams and for more educated white women, 44 grams; both relationships were highly significant. Among black women, the estimated effects of WIC program enrollment on mean birthweight was 26 grams for the less educated and 34 grams among the more educated. These relationships were not significant (p = 0.10 and p = 0.13, respectively); but the statistical power of the analyses for black women was much lower than for white women because of the small number of counties available with sufficiently large numbers of black births.

The estimated decrease in the proportion of births under 2500 grams was four per thousand deliveries among WIC beneficiaries, about 6% to 7% of the expected rate of low birthweight in the population recruited into the WIC Program. WIC was associated with a reduction in low birthweight of 15 per thousand deliveries among less educated black women and 18 per thousand deliveries among more educated black women. While important, they were not significant (p = 0.11 and p = 0.07, respectively).[52] There was no relationship between WIC program penetration and the rate of very preterm delivery (under 33 weeks duration), but there was an association at the margin of statistical significance (p = 0.09) between WIC and less frequent preterm delivery (under 37 weeks gestation) for the total population. There was significantly longer mean duration of gestation associated with the level of WIC penetration.

There was a stronger relationship of WIC benefits to better outcome among both white and black women with less education compared with women with more education. There were substantial and significant reductions in preterm (under 37 weeks) delivery among less educated white and black women associated with the WIC program. The estimated reduction in preterm delivery among less educated white women was 23% (18 per thousand deliveries) and among less educated black women, WIC enrollment was associated with about a 15% reduction (20 per thousand deliveries). The preterm delivery rate was unaffected by WIC among more educated women, black or white. The WIC program was also associated with a significantly longer mean duration of gestation of about 1.5 days among less educated white women. Thus, in the Historical Study, the relationship of WIC penetration with duration of gestation was reported as consistent and strong while it is noted that other health programs targeted to the poor could theoretically have accounted for these relationships, the sum of research on this issue the report indicates is not consistent with this conclusion.

In the Longitudinal Study of Pregnant Women, there were no significant differences between the birthweights of infants of women enrolled in the WIC program and those of women in the control group nor were there differences in the frequency of birthweight under 1500 grams or under 2500 grams. This absence of difference the report notes may be because of the lower health risk and higher social status of women in the control group, which could only partially be accounted for by statistical adjustment. While these comparisons were not statistically significant, the perceived quality of local WIC programs by state WIC Directors was reg-

ularly and significantly related to increased mean birthweight and to decreased frequency of low birthweight. Unexplained is the lower late pregnancy fat stores reported in WIC women.

The estimated difference in mean birthweight among clinics separated in quality by two standard units (between the 16th and 84th percentiles of perceived program quality) was 51.2 grams, or slightly greater than the effect of the WIC program that originally had been predicted when the study was designed. The frequency of birthweight under 2500 grams was also significantly lower the higher the quality score ($p = 0.01$) (Table IV).

A recent report has also suggested that continuing to receive WIC supplementation during the interpregnancy period can help to increase birthweight in subsequent pregnancies.

A recent report has also suggested that continuing to receive WIC supplementation during the interpregnancy period can help to increase birthweight in subsequent pregnancies. The investigator compared the birth outcomes of a group of women who participated in WIC during a first pregnancy, continued to receive WIC in the interpregnancy period, and remained in the program during a second pregnancy, with a group of women who also participated in WIC during both pregnancies but received very little supplementation in the interpregnancy period. The difference in mean birthweight adjusted for gestational age between the two groups was 160 grams.[52] It is important to note that WIC is a three-part intervention program involving supplemental food, nutritional counseling, and close ties to prenatal care. Research to date has not isolated the differential effects of the three WIC components.[43]

WIC is not the only prenatal nutrition intervention program that has been associated with improvement in low birthweight status. Results from other countries are consistent with the WIC results, although the applicability of the programs evaluated to the United States may be limited.[54,55] Prenatal participation in the United States Commodity Supplemental Food Program also has been associated with a decrease in the low birthweight rate among participating women.[56]

Estimating Program Impact

By applying the above reported 20% average reduction to the low birthweight rate of 115/1000 live births born to the 110,601 women, with less than 12 years of education in 1982 on public assistance; WIC program impact may be estimated. A 20% reduction in this group results in a decrease from 115 to 92 low birthweight infants/1000 live births. This reduction of 23 low birthweight infants for every 1000 births will have an important impact. This includes: (1) An estimated decrease of 10% in infant mortality. This translates into a decline in the infant death rate of 2.3 infants per/1000 live births. This will result in a decrease of 254 infants death in this high-risk group of women alone. The assumption in this model is consistent with the observed decrease in neonatal mortality in the historic study of the National Evaluation and the low birthweight reduction in the GAO report. (2) An estimated savings in intensive care hospital costs conservatively estimated by the Institute of Medicine in 1984 dollars to be $13,616 per low birthweight infant. By preventing 2544 low weight births and the associated cost of hospitalization of women there will be a savings of $34,639,104 in medical and hospital costs. (3) In addition there will be a savings of $5,580 per rehospitalized low birthweight infants. This rehospitalization is estimated by The Institute of Medicine to occur in 20% of all surviving low birthweight infants in the first year of life. This will result in a savings of $4,580 × 509 infants or $2,840,220 in this cohort of high-risk, low-income mothers and infants. (4) Further, a savings of $1,405 per year, estimated by the Institute of Medicine, will be realized for the 18% of surviving low birthweight infants requiring long-term care. This is estimated to be a recurring annual cost of $1,405. Reduction in the number of low birthweight infants will result in a savings of $643,490 per year for the 458 infants in this cohort estimated to require this additional care.[43]

Thus, for this one cohort alone of high-risk infants born to poorly educated women on public assistance a positive WIC program effect may result in a 20% reduction in low birthweight infants. This can result in a savings of $38,122,814 in direct medical costs in 1984 dollars. Available evidence suggests that nutrition intervention programs, like WIC have a quantifiable effect on the population they serve. Program effects are most clearly seen in high-risk pregnant women. There is an increase in birthweight and a reduction in preterm deliveries before 37 weeks gestation. This leads to a decrease in neonatal morbidity and mortality. The result is not only improved pregnancy outcome but a reduction in health care costs.[52]

SUMMARY

Poor pregnancy outcome and low birthweight have been a health concern through the centuries. It is only recently that we have been able to define the problem and even more recently to refine our thinking to specify the differential impact of nutritional and other environmental insults that will influence fetal growth before and during different stages of pregnancy and fetal growth. The role of low prepregnancy weight, inappropriate maternal weight gain and poor health status are being increasingly understood as important elements in the fetal growth equation. The role of the placenta and its growth, reflecting the overall status of the pregnancy is equally critical in influencing fetal nutrition. It is clear that nutrition intervention during pregnancy may reverse or modify a poor pregnancy outcome. The effect may be particularly evident in those pregnant women who are at the greatest bio-social risk for a poor pregnancy outcome.

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PREPARED STATEMENT OF CAROL TRENT WALKER

Good morning, my name is Carol Walker. I am here at the request of the Maryland Food Committee and Representative Boxer to talk about the Special Supplemental Food Program for Women, Infants, and Children (the WIC program).

I first became aware of the program 4 years ago, purely by accident. I was pregnant with my son, Dan III, and happened to see a public service announcement about the WIC program. Figuring nothing ventured, nothing gained, I called the number that was given at the end.

My husband and I were both working at that time, and the caseworker I spoke with told me I was not eligible for WIC due to our combined income level but, to call back if anything happened to change that.

My son was born in December of '86, two months later, in February of '87, I was laid off. After my unemployment and severance pay ran out, things were tight, so I called the WIC office again. The caseworker explained that WIC has 2 eligibility requirements, income level and health.

Since we were living off my husbands income of $180.00 a week, we fell under the guidelines for income, so Dan III and I went in for a Health check. Dan was underweight and had a low iron level, I received vouchers for him for cereals and juice, and since I was breast-feeding I received vouchers for milk, cheese, eggs, dry cereal, peanut butter and juice.

When Dan turned a year old, I stopped receiving vouchers. Dan will continue to receive them until he is five.

Every 6 months we go in for recertification. At this time our income level is checked (via pay stubs) and our residency is verified by a utility bill, our health is also checked. We are also given advice on ways to improve our health and nutrition.

The WIC program has allowed us to stretch our food dollars. There were times when the only food in the house was what we received from WIC.

The WIC program helps thousands of families similar to ours, young families trying to improve their lives. In addition to the 60 hours a week my husband works, he attends college 4 nights a week, and I am also attending college. My goal is to open a day-care center in my home, when we are able to purchase one.

I only have 2 concerns about the WIC program. I would like to see a program implemented, and greater emphasis placed upon teaching pregnant women about the benefits of breast-feeding.

My second, and main concern, is for families who are struggling to survive on one income. I know of a family of two, a woman and her infant son, who were receiving food from the WIC program. When the mother, who has to work and therefore has to pay for daycare for her son received a minute pay raise, her son was out from the WIC roles.

I feel that the program needs additional funding to provide for these families.

Thank you for your kind attention and support.

PREPARED STATEMENT OF DENISE V. FERRIS

Thank you for the opportunity to appear before you today. My name is Denise Ferris, Director of the West Virginia WIC Program, and I would like to speak to the problems facing this program in my state.

The WIC Program in West Virginia served 30,519 in 1988, and 30,868 in 1989 with Federal funds. West Virginia started to build caseload early in FY '90 in anticipation of additional dollars generated by Infant Formula Rebate. We began conservatively, continuing the policy started in 1989 of serving only Priorities I,II, and III. However, we soon realized that we would not be able to serve all of our Priority III's even with the average caseload of 34,620 in FY '90, and continued the policy of not serving Priority IV, V, or VI. As food prices continued to rise through the late fall and into early spring, we considered the options to either reduce caseload or to reduce the food package. Throughout the discussion, the State Nutrition Staff was opposed to decreasing or limiting the food package, since the WIC Program would lose its effectiveness if the food prescribed is not actually consumed. Peanut butter and beans have always been limited to certain risk codes. The eligible food list, was revised in April 1990, which included some cost-saving measures. The final decision, to decrease caseload through a reduction of Priority III's, was made with regret. Since most of the State Nutrition Staff have had Local Agency experience, we know how difficult it is to tell a participant face-to-face that they will no longer be receiving benefits. West Virginia has experienced a 14% increase in milk prices in the last year, and a 25% increase in formula in the last 18 months.

There are many administrative problems involved in managing the Priority III caseload. We currently have in place a scoring system within Priority III, in which children must be screened in order to determine their score. Children may be put on a precertified waiting list if their score is not being served. After 60 days (the limit for medical data), children must be screened again if a slot

becomes available. Although this system is burdensome, the local agencies wanted a very fair way of caseload management, so that 3 and 4 year-olds with many medical problems could still be served before younger, healthier children. However, these unserved children with inadequate diets are likely to develop health problems and become Priority III's. WIC becomes a revolving door, as children go on and off the Program! The physical and mental growth and development of these children cannot be put on hold until we have the funds available to serve them. The preventative aspects of an adequate diet are not being addressed by current funding levels.

Along with caseload reductions comes negative publicity. In spite of our best efforts, caseload reductions are perceived as "the Program has been cut" or is "out of money". The results of this are that the no-show rate for current participants climbs, and potential participants are reluctant to apply, assuming that they will not get on. In this round of caseload reductions, we even have had situations where current participants (including pregnant women) call the Program and ask that they be taken off so that someone more needy may have their slot.

Decreasing caseload has far reaching effects. With less family members on the Program, I believe that the food package is being diluted by increased sharing of food in families. Many pregnant women share the food with their other children who we cannot serve, in spite of our efforts to educate her that the food package is designated for her and her unborn baby. This limits the benefits of the food package, and I am concerned that we may see an erosion in the gains made in improved pregnancy outcome if this situation continues.

The inability to serve low-scoring Priority III's, and none of Priority IV, V, and VI in West Virginia also affects our outreach efforts. We approach outreach cautiously, knowing that our efforts result in a flood of inquiries from the potentially eligible population that we know we cannot serve in the near future. This results in frustration for the unserved population as well as the local agencies that must deal with the public. Additionally, our waiting lists are filled with unserved Priority III's, and it is a futile effort to keep a list of lower priorities. Earlier in this fiscal year, it was estimated that there were 3,300 participants on waiting lists in West Virginia.

There exists a great unmet need even within the priorities we are serving. Slightly over 50% of all births in West Virginia were to women on Medicaid and other state funded prenatal care programs, and we have a long way to go toward the goal of reaching all Priority I women. For infants whose mothers were not on WIC when pregnant, it takes a great

effort to get them on as soon as possible. As much as it discouraged, the WIC Program is often looked upon as an emergency food source, and local agency staff must scramble to get these infants on as soon as possible. Just last month, I had a conversation with a sobbing mother who was knowingly writing bad checks in order to get formula for her baby. There was no safety net for her infant, as is true for many other infants in West Virginia.

The WIC Program in West Virginia does have an impact on the participants. It is not unusual to enroll pregnant women with very little cash income, and that income goes for rent or trips to the doctor. WIC also helps make participants more aware of the importance of health care, and especially prenatal care. Some participants have written to the State Agency to express their feelings about the WIC Program. Here are a few excerpts: "I am writing in regards to let the people who served me at W.Va. WIC, know how thankful I am for their help in promoting good nutrition for me and my child for the past five years. You also had genuine concern for my child and you really cared about her diet. So thank you very much for showing and guiding me to good nutrition and a healthy life. Good luck with other families and to a healthy life yourself." (Dated March 1, 1990 from Cowen, WV.) "This past week at my WIC appointment I was informed that my 3 year old son is no longer eligible to be on the program because he is in such good health. I couldn't let the program end without saying thank you for everything. We have been on WIC since I became pregnant and I can't begin to tell you how much it has helped us over these past years. This program helps so many people, they may not all appreciate it as much as I have, but I hope so. I truly believe that the reason my son <u>is</u> so healthy is because of WIC." (Dated March 28, 1990, from Summersville, WV.)

Unfortunately, we cannot be optimistic about the growth of the WIC Program in West Virginia for FY '91. To briefly address the Infant Formula Rebate issue, West Virginia began this measure in June 1989. The public bid opening for our next contract will be June 28, 1990. We have been tracking the declining rebates offered this year and it is a cause of great concern. If a 75 cent bid is offered, it is projected that this will result in a reduction of approximately 2,000 participants per month in West Virginia. I feel that West Virginia did not benefit from the initial wave of high rebates. The concern is that now West Virginia may be among the first to be affected by the current wave of declining rebates.

There is currently a bill in the West Virginia Legislature this session that would provide a one-time additional $400,000 to assist the WIC Program in avoiding caseload reductions for the remainder of this fiscal year. The state WIC Program and the participants that will benefit from this

generous gesture are grateful, but I think that it is not feasible or realistic to expect that individual states will be able to continue this type of assistance. The West Virginia State WIC Program estimates that our potentially eligible population served is about 30%, and I do not believe that our state is in the position to fund the WIC Program to the extent that we can make a significant impact on the potentially eligible population served.

In closing, I urge the Congress to appropriate at least the $2.36 Billion specified in the House Budget Resolution for FY '91, and any additional funds if the WIC Program is to expand next year.

Thank you for the opportunity to share my concerns with this committee. I will be most happy to answer any questions you have.

PREPARED STATEMENT OF LINDA BARR GALE

Thank you for this opportunity to speak today about the important funding problems now facing the WIC Program. I am Linda Barr Gale, Director of the New York State Department of Health's Bureau of Nutrition. As both a nutritionist and a health administrator who has had responsibility for managing WIC Programs for the past 16 years, I have been involved with and gained perspective on the evolution and dynamics of the WIC Program. Sixteen years with WIC has given me a broad range of experiences; I have been fortunate to help develop the evaluation instrument used in the National WIC evaluation, helped start the National Association of WIC Directors, helped to establish the infant formula rebate strategy as a member of the NAWD Cost Containment committee, helped implement nutrition surveillance and helped develop WIC National policies and procedures. Today, like my colleagues, I am doing my best to help prevent WIC Program participation from this shameful erosion.

Declining WIC participation in New York State has been a concern since 1984 when a new federal funding formula was used to channel growth funds into states falling below the national average WIC caseload. These states were called "equity" states by USDA. Non-equity states, like New York, serving a higher percent of caseload than the national average were expected to have their caseload stabilized through adequate yearly inflationary increases added to the prior year's base grant. But, New York State's WIC caseload actually dropped during this period. In response, we began a major cost containment initiative in 1986. We pared down our food package items, designed a sophisticated new WIC banking system, placed payment restrictions on retailers for WIC foods and implemented aggressive legal action against any WIC retailers overcharging the program which included an agreement with the Food Stamp Program to prevent violating stores from participating in the Food Stamp Program. Through these initiatives New York directly and significantly lowered food package costs and began serving an additional 70,000 people per month. In 1989 New York implemented an infant formula rebate system allowing another 50,000 clients per month to be served. We lowered our costs by 27%. This was one of the largest and most successful cost containment efforts nationally, and allowed us to increase our caseload by some 120,000 people. But our success in cost containment has in fact masked the yearly decline in federal support as a consequence of inflation.

For example, in FY 1988 federal WIC funds supported 261,191 New York WIC clients; our actual inflation rate was 6.3% but we received only 3.9% for inflation from USDA (See Attachment #1). Similarly in FFY 1989 our actual inflation rate was again 6.3% but we received only 4.4% from USDA to "stabilize" our caseload. Subsequently, if we strip away the effect of the infant formula rebate, our FFY 1989 caseload supported by Federal WIC dollars dropped to an average of 259,000.

Continuing with our downward trend it is not surprising that the current FFY 1990 appropriation level is inadequate to maintain our prior year's federally supported WIC caseload of 259,000 since USDA offered an inflation factor of 4.09% for FFY 1990 while our inflation for the first 6 months has actually reached 9.1% and is estimated to reach 13% by September. Sharply rising prices for milk (12%), eggs (22%), cereal (8.6%), and juices (10%) have reduced New York's federally supported

caseload average by 10,000 women and children as of March and is projected to drop our caseload average by 18,800 by September. Attachment II clearly shows how New York's federally funded WIC caseload has eroded due to inflation. The New York WIC Program expends one twelfth of its federal WIC funding each month. In October 1989 one twelfth of WIC funds served 259,745 people by April 1990 of this fiscal year one twelfth of federal WIC funds served only 230,970 people; by September 1990 only 223,097 people are projected to be served by this same level of federal funding, a drop of over 36,000 people in one year.

The caseload decline this fiscal year has been so significant that the overall New York State WIC caseload is also dropping despite our infant formula rebate and infusion of $42.3 million in State funding -- by far the largest state support nationally. Clearly the immediate problem for New York State is an eroding WIC funding base due to insufficient federal funds to cover the inflation of WIC food items.

New York State would need an additional $5 million to stabilize our current federal service level of 259,000 people for FY 1990. Secondly, the opportunity for serving additional high risk individuals is lost under the current appropriated level even though the New York WIC eligible population is growing. Even using conservative and much too low USDA estimates, we are serving less than 45% of the eligible population in New York State. Growth funds are being used by equity states to cover inflation. This lengthens the time it will take for these states to come closer to the national caseload average. The national average caseload is going up mostly because of the infant formula rebate.

The House-passed Budget Resolution for FY 1991 which would provide a multi-year expansion of the WIC program will stabilize federal support for New York State only if adequate inflationary increases are provided. This requires that the current FY 1990 base grant be adjusted to allow for the actual inflation rate experienced during FY 1990, a $52.5 million adjustment nationally. To this readjusted FFY 1990 base grant, the projected 1991 inflation rate for WIC food items should be added to allow for stabilization of current services. For New York State, this would require readjusting upward the current FY 1990 base grant by $5 million. This new base grant should then be increased by 7.1% (our past four year average rate of inflation) to compensate for the projected inflation of WIC foods expected during FFY 1991, a $139 million increase nationally. Therefore, stabilizing current WIC services levels will require an additional $191.5 million.

At present, the House-passed Budget Resolution for FY 1991 makes no adjustment for FY 1990 actual food price inflation. Moreover, the Congressional Budget Office is using 4.2% for inflation based on the Consumer Price Index for FY 1991. This will result in a continuously eroding federal funding base and a concomitant WIC caseload decline so that by FY 1995 we estimate federal support will cover only 214,000 WIC participants, a decrease of 16.9% since 1989. If inflation is not matched by increased funding all states will be adversely affected, even states receiving growth funds because growth funding will not be used for "growth" but for caseload maintenance.

New York State concerns pertaining to a continually declining WIC caseload are exacerbated by the recent news that states are receiving lower rebates from the infant formula manufacturers. New York's sole source infant formula rebate is $1.50/13 ounce can. The rebate will generate $42 million this year and will continue through January 1992 with adjustments for the manufacturer's price increases. Manufacturers have indicated that a $.75/13 ounce can may be their bidding approach in the future. If this tack is taken with New York, the WIC caseload average will be reduced by 40,000 clients. As a consequence, New York has begun working with the New England states to explore a unified, regional infant formula rebate proposal.

Sixteen years with the WIC Program has allowed me to appreciate the impact this effective public health program can have on high risk women, infants and children. WIC increases birthweight, increases the length of gestation, lowers fetal deaths, improves maternal weight gain, reduces anemia and improves nutrient intake. WIC is targeted to a particularly

important population experiencing rapid physiological growth and development. WIC is timely since it introduces needed dietary change when individuals are more accepting of change. WIC offers people foods they want, in a form they can use and easily obtain. WIC works because it assesses individual needs, prescribes foods and services liked and needed by the client, and emphasizes complete use of the food and related services for the improved health of the mother and her children. WIC saves money because it actually prevents medical expenses, educational problems and wasting of our human resources.

WIC programs across the nation are running out of ways to further reduce WIC costs without reducing participant caseload or reducing WIC food items. Pressures to eliminate food items from the WIC food package threaten to chisel away -- and chisel is the word -- the extraordinary effectiveness of this program. Currently, the Congressional Budget Office (CBO) uses the Consumer Price Index to determine inflation for WIC. The U.S. Department of Agriculture (USDA) bases the inflation factor on the Thrifty Food Plan from the Food Stamp Program, which does not present an accurate picture of the WIC costs. This problem must be corrected by requiring CBO & USDA to base the inflation factor on actual WIC food items rather than the CPI or Thrifty Food Plan. Until states are given accurate inflation allowances in their funding allocations, WIC Program growth will be a myth as states are able to serve fewer and fewer WIC-eligible mothers, their babies and children.

Congress has the power to make the WIC program more effective and more far reaching in its application. I come before you today to urge you to use that power wisely and well in the cause of better maternal and child health.

ATTACHMENT I

NEW YORK STATE WIC PROGRAM PROFILE

FEDERAL FISCAL YEAR	FEDERAL GRANT INFLATIONARY INCREASE	NYS ACTUAL INFLATIONARY INCREASE	FEDERAL GRANT SUPPORTED CASELOAD	% CHANGE	REBATE SUPPORTED CASELOAD	% CHANGE	TOTAL CASELOAD (Fed. + Rebate)	% CHANGE
1988	+3.93	+6.30	261,191		0		261,191	
1989	+4.40	+6.32	258,256	-1.1%	53,923		312,179	+19.5%
1990 *	+4.09	+9.1	248,630	-3.7%	81,000 ***	+50.2%	329,630	+5.6%
1991 *	+4.20	+7.1	241,432	-2.9%	75,630	-6.6%	317,062	-3.8%
1992 *	+4.15	+7.1	234,444	-2.9%	50,020 **	-33.8%	284,464	-10.3%
1993 *	+4.15	+7.1	227,658	-2.9%	32,967	-34.1%	260,625	-8.4%
1994 *	+4.15	+7.1	221,064	-2.9%	30,782	-6.6%	251,850	-3.4%
1995 *	+4.15	+7.1	214,669	-2.9%	28,741	-6.6%	243,410	-3.4%

* PROJECTED
** ASSUMES 50% REDUCTION IN REBATE/CAN, FROM $1.50 TO .75 EFFECTIVE FEB. 1, 1992
*** FIRST FULL YEAR OF REBATE REVENUE

6/90
NYS DEPT OF HEALTH
BUREAU OF NUTRITION

NEW YORK WIC FACT SHEET
FFY 1990 WIC Caseload Decline

(A) Month	(B) Federal Expenditure	(C) Federally Supported WIC Caseload	(D) Infant Formula Rebate (IFR) Revenue	(E) Infant Formula Rebate Supported Caseload	(F) Total Federally Supported & IFR Supported Caseload (C + E)	(G) Federal Reappropriation Funds	(H) Additional Caseload Supported by Federally Funded Reapprop	(I) Total Caseload (C + E + H)
Federal Fiscal Year 1990								
October 89	$10,743,237	259,745	$3,401,292	82,235	341,980			341,980
November	10,743,237	254,349	3,473,899	82,246	336,595			336,595
December	10,743,237	248,848	3,470,255	80,382	329,230			329,230
January	10,743,237	243,511	3,563,854	80,780	324,291			324,291
February	10,743,237	241,548	3,541,558	79,628	321,176			321,176
March	10,743,237	239,045	3,617,355	80,489	319,534			319,534
April	10,743,237	230,970	3,666,388	78,824	309,794			309,794
May	10,743,237	229,778	3,500,000	74,858	304,636			304,636
June	10,743,237	228,070	3,500,000	74,302	302,372			302,372
July	10,743,237	226,388	3,500,000	73,754	300,142	$344,372	7,257	307,399
August	10,743,237	224,731	3,500,000	73,214	297,945	344,372	7,204	305,149
September	10,743,237	223,097	3,500,000	72,682	295,779	344,372	7,151	302,931

PREPARED STATEMENT OF DEBRA STABENO

My name is Debra Stabeno and I am the Director for the Texas WIC Program. I appreciate the opportunity to testify before your task force because the WIC Program is tragically underfunded in my State as well as many areas of the country.

We entered FY90 after having added over 100,000 low income nutritionally at risk women, infants and children per month to our WIC Program in addition to initiating services in 40 previously unserved counties with funds generated through our infant formula rebate program. That increase in participation, 45% in 21 months, was larger than we had been able to accomplish with appropriated funds increases in the past five fiscal years taken together. That expansion effort enabled us to reach a little over 350,000 women, infants and children per month or an estimated 27% of our potentially eligible population prior to the reductions we have been forced to make in the past few months.

We entered FY90 maximizing our funding from all sources to include federal and state appropriations as well as our infant formula rebate income (See Attachment I). We also anticipated that there would be some FY89 unspent funds from other states that would be reallocated later in the year. Because we had an additional state appropriation available in September 1990 as a cushion, we set our FY90 caseload target at 350,000 participants per month assuming an approximate 4% inflation allowance on our FY89 average food package cost of $27.97.

In addition our infant formula contract would be rebid in FY90 and we were optimistic that we would secure a higher rebate. Winning rebates in states bidding contracts in FY89 and the first 4 months of FY90 exceeded the rebate levels in Texas. Based on these facts, in addition to our large volume of infant participants, we were hopeful that a higher competitive rebate level (income) would be secured. All these factors indicated that we needed to maintain caseload levels (350,000 per month) for FY90 to fully utilize all available funds for their intended purpose. Virtually FY90 was planned as a no-growth maintenance mode year for the Texas WIC Program.

In reality WIC managers must make funding decisions well in advance of notification of appropriation levels or reallocation amounts. Basically if we waited until we had official letter of credit authorization to amend local agency contracts, allocate additional caseload, hire staff, etc., we would never be able to spend all our money and more people would go unserved. We have to make decisions in advance, monitor the situation closely and be prepared to make adjustments as any information changes.

Unfortunately, Texas saw a dramatic increase in food costs (9.8%) (See Attachment 2) in the first 4 months of FY90 which far exceeded the amount estimated as an inflation allowance. This coupled with an unprecedented demand for our services from high priority participants placed the Texas Program in serious financial difficulty and necessitated substantial reductions/changes in our food package/redemption policies in addition to being forced to reduce our rolls by some 27,000 WIC participants in our lower priority categories (Priorities IV, V, VI) as their eligibility expired.

As the first financial information for FY90 became available in December 1989, a caseload management plan to curtail growth was initiated and caseload levels were reduced statewide. By January 1990 our food package cost per participant had reached $31.93 with no end to cost increases in sight. Without intervention, food package costs would have gone even higher, up to an estimated level of $33.00 per participant. With anticipated service to an average of 350,000 clients per month, the Texas WIC Program projected a deficit of $14.7 million by the close of FY90 if additional action

was not initiated or additional appropriated funds were not secured.

The Texas WIC Program outlined the following plan of action in January 1990. We also wrote our congressional delegation asking for their help in securing a supplemental appropriation.

FOOD PACKAGE/POLICY CHANGES

(1) Required WIC participants to purchase the least expensive brands of certain food products, i.e., evaporated milk, cheese, juice and peanut butter.

We had initiated the least expensive brand concept with fresh milk back in August, 1988.

(2) Tightened our vendor pricing policy so that only the vendors with the most competitive prices retained their ability to redeem WIC cards.

(3) Reduced the food packages for postpartum women and young children based on the newly published RDA's.

(4) Developed a plan to directly distribute to WIC infants the balance of sample formula due under our current contract with Mead Johnson.

(5) Tightened the policy on issuance of powdered infant formula because the price of powdered formula rose significantly more than that of concentrate formula.

(6) Made a decision to temporarily eliminate the issuance of cheese to the majority of WIC participants (for 4 months June - September 1990) and replace the package with additional fresh milk.

(7) While investigating the possibilities of competitive bids for WIC cereals, we have reduced the number of brands available to seven, (out of a possible 37 brands) which represents the least expensive in several grain categories.

CASELOAD MANAGEMENT POLICIES

(1) Effective January 1, 1990, we eliminated enrollment or recertifications of older children and postpartum women who had less than 4 months of eligibility remaining on the program.

(2) Effective March 1, 1990, we eliminated enrollment or recertification of priority VI postpartum women and 3 and 4 year old priority V children.

(3) Effective April 16, 1990, we eliminated enrollment or recertification of women, infants and children in priorities IV, V, VI. This represents those individuals who are at nutritional risk due to an inadequate diet but who have yet to develop clinical signs of malnutrition. In addition, our local agency caseload slots were reduced statewide by approximately 9,000 slots per month for May, June and July. In effect as lower priority participants left the program, we restricted our local agencies ability to fill the slots.

(4) Effective June 12, 1990, we froze caseload slots at May levels. Because we had experienced a larger drop in participation sooner than anticipated (probably due to all the press coverage about cuts in the program) totaling approximately 22,000 women, infants and children for April and May, provisions have been made to minimize our reductions to the extent possible.

CONCERN WITH REQUIRED ACTIONS

Texas officials have the following concerns with the actions we have been forced to make during FY90.

(1) By eliminating service to priorities IV, V, VI, we have virtually eliminated the prevention aspect of the WIC Program, one of the primary purposes of the program. We fully expect that the health and nutrition status of these people will regress and clinical signs of inadequate nutrition will be apparent in several months (increased anemia, inadequate growth rates, etc.).

(2) The initiation of waiting lists and the demand for existing appointments (causing some 1-2 month delays) create barriers to potential high priority women, infants and children. We are fearful we may never see some of our clients back in clinics - not only for WIC but for other critical public health services such as prenatal care, immunizations and family planning.

(3) As a result of recent caseload actions, the Texas Program is tremendously underserved dropping to only 25% of our eligible population by July of 1990. An example of the disparity in our state's unmet need is that Texas WIC services only 40,000 pregnant women with family incomes up to 185% of the federal poverty level. The Texas Medicaid Program, which serves only up to 133% of the federal poverty level, is currently serving some 62,000 pregnant women. This fact alone indicates we still have a long way to go to reach even our highest priority participants.

(4) Ironically, a recent positive change in the Child Nutrition and WIC Reauthorization Act of 1989 (P.L. 101-147) increased inter-program coordination and actually mandated adjunctive income eligibility with three major entitlement programs, i.e., Medicaid, AFDC and Food Stamps. These measures will have a dramatic effect on our WIC Program reducing a significant barrier to WIC participants who have already been through an intensive income screening in these other programs. Unfortunately the result in Texas will be that thousands of low income, nutritionally at risk women, infants and children will be referred to WIC only to be placed on a waiting list or to be told they are not eligible based on the state's current caseload management policies. Surely Congressional intent was not to reduce significant barriers to participants only to turn them away due to lack of funds to serve them.

(5) Basically, WIC participants in Texas do not enjoy the same benefits as participants in other states in regards to the food package. We feel we have exhausted all cost containment alternatives available at the risk of jeopardizing the overall benefits of the food package. In example:

a. If at all possible, we plan to reinstate cheese to the food package in FY91. This change was done as a last resort to save money rather than reducing service to several thousand additional participants. We feel strongly that the long-term elimination of cheese from the food package would seriously diminish the food package.

b. We have virtually eliminated brand choice for most of our items, i.e., infant formula, milk, evaporated milk, cheese, juice, peanut butter and cereal. This may reduce the overall redemption rate of food coupons and thus threaten the effectiveness or desirability of the program for some participants.

c. Although the reductions made to the food packages for postpartum women and younger children are based on the latest published recommended daily allowance (RDA's) of certain vitamins and minerals, WIC participants have been defined as a "high risk" group. Basically, one can meet the RDA's and still be hungry or have an inadequate diet. This concerns us.

d. We have concern about the effectiveness and use of the food packages we are able to provide. In example, if we provide a food package for a high priority pregnant or breastfeeding woman but her children are not eligible to participate because of caseload management, program officials know the woman's food package will be shared thus reducing the overall benefit to the mother. The participants are forced to make tough choices.

ANALYSIS OF FUNDING NEEDS TO REVERSE CUTS IN FY90

As stated above, the Texas WIC Program tried to minimize the number of people reduced from the program by modifying the food package for some categories of participants, restricting brand choice for the majority of food types as well as supplementing food cost with a one time use of administrative money that would otherwise have been used to increase the available administrative and program services funding for local agencies. The analysis of these actions is as follows:

FY90 Estimated Expenditures If No Action Taken	$135,313,793.00
FY90 Available Food Foods	- 120,604,837.00
Shortfall	$ 14,708,956.00
Less Least Expensive Brand Savings	<$ 539,000.00>
Shortfall	$ 14,169,956.00
Less Reduced Food Package Savings	<$ 4,725,000.00>
Shortfall	$ 9,444,956.00
Less Substituting Milk for Cheese Savings	<$ 2,772,000.00>
Shortfall	$ 6,672,956.00
Less Savings from Reduction in Caseload (22,000 X 5 months X $28.52*) (*Average Food Package Cost After Changes Last 5 Months of FY90)	<$ 3,137,200.00>
Shortfall	$ 3,535,756.00
Less Savings from One Time Conversion of Administrative Funds to Cover Food	<$ 2,759,345.00>
Shortfall	$ 776,411.00*

*Obviously there are still too many variables remaining to more closely predict year end expenditures. Should the shortfall outlined exist at year end, it will be covered from our FY91 state appropriation available September 1, 1990.

FOOD FUNDING NEEDS FOR FY91

If we were to re-establish the food package as it existed in January, 1990 (when we began to reduce and restrict it) and maintain the 350,000 participation level of October 1989 and projected target for FY90, the Texas WIC Program would need in FY91 food funds of $140.5 million or 16.5% above current year grant (FY90) levels including state funds and FY89 carryforward and

reallocation (See Attachment 1). This calculation assumes a 4% inflation adjustment for a projected average food cost of $33.45 for FY91.

If Texas receives in FY91 the portion of the national appropriated WIC food funds that it received in FY90, (See Attachment III) then we would receive $126.8 million if the House budget proposal is adopted. This amount added to our FY91 state food funds of $4.3 million would total $131.1 million or a 8.7% increase over FY90 available food funds. Under the NAWD proposal, Texas would receive $129 million in federal food funds added to the $4.3 million in state food funds for a total of $133.3 or an 11% increase over FY90 available levels.

Both proposals would fall substantially short of meeting maintenance (350,000 per month) and Texas would be unable to expand to serve the ever increasing need.

Therefore, Texas would be forced to leave some food package reductions in place. We would do everything possible to restore cheese to the food package. By returning cheese to the food package in FY91, Texas would serve the 350,000 level with food funds of $127.7 million or 5.9% above our current available food funds. (This assumes an average food package cost of $30.40 which has been inflated by 4%). Texas could then use the 2.8% (House budget) or 5.1% (NAWD proposal) difference in available funds for growth. Texas would still fall short of the intended expansion or growth funds intended in the appropriation of 6.8% ($.150 billion divided by CBO level of $2.211 billion = 6.78%).

If Texas opted to restore reductions in the food package for one and two year old children in addition to restoring cheese, the 350,000 level would require $137.8 million or 14.3% above our current available food funds. This assumes an average food package cost of $32.80 which has been inflated by 4%. Both the House budget and NAWD proposals would fall short of this objective and would obviously provide no opportunity for growth.

In conclusion, Texas' share of the House proposed national appropriation levels will not allow us to regain FY90 target levels of 350,000 per month and will ensure no expansion of the program if needed food package cuts are restored. If funding were available Texas could easily and realistically offer services to some 400,000 women, infants and children per month in FY91 and more in the future. The demand for our services is that great! The cost to serve 30% of our potential eligible population, restore cheese and the food package reductions for young children would require the following food funds.

400,000 Participants X 12 months X $32.80 Average FY91 FEP = $157,440,000.00.

This represents a $36.8 million dollar or a 30.5% increase in available food funds over FY90 levels.

INFANT FORMULA REBATE STATUS IN TEXAS

On April 27, 1990, the Texas Department of Health opened sealed bids submitted in response to an Invitation for Bid (IFB) for a rebate offer for a sole source WIC formula. The contract resulting from this IFB will become effective October, 1990 upon the expiration of a prior sole source contract which commenced 29 months earlier.

The requirements set forth in the IFB were detailed and specific with the vendor required to sign a certification form agreeing to all requirements, terms, and conditions of the IFB. All potential bidders were subsequently informed that a bidder who changed a requirement, term, or condition would be non-conforming and the bid would not be considered.

All three companies which manufacture both milk and soy based

formulas submitted bids. They were:

Mead Johnson Nutritionals, Wyeth Laboratories, and Ross Laboratories

(1) Mead Johnson signed the vendor certification agreeing to all the requirements, terms, and conditions. Mead Johnson offered the highest net effective rebate which was $1.251 per can.

(2) Wyeth Laboratories signed the vendor certification agreeing to all the requirements, terms, and conditions. Wyeth offered a net effective rebate of $.89 per can.

(3) Ross Laboratories signed the vendor certification but made substantial changes to the requirements, terms, and conditions of the IFB. The Ross bid was determined to be non-conforming. Ross offered the lowest net effective rebate which was $.502 per can and included the following changes to defined bid specifications:

a. Ross does not agree to deliver to local WIC clinics as directed by the State, approximately 1,420,000 cans of 13 ounce concentrate and/or formula equivalents, free of charge, during the twenty-four month contract period.

b. Instead, Ross can provide free of charge to local WIC clinics for client distribution in emergency situations a supply of Similac with Iron or Isomil Soy Protein Formula with Iron. Such supply shall not exceed <u>one can of concentrated liquid equivalent per WIC participant</u>.

c. This exception would result in a 1,322,000 can shortage of donated formula needs.

d. Ross does not agree to wholesale price increases automatically increasing the net effective rebate by the same amount.

Instead the Vendor proposes that any rebate adjustment will be based on the same percent off the wholesale truckload price as the bid shown on the quote sheet. The percent off the wholesale truckload price as shown on the quote sheet is 29.634%.

Vendor had a price increase April 2, 1990, of $.136 which would increase the net effective rebate to $.638 effective with contract implementation. Utilizing the Vendor's method would result in a net effective rebate of $.5423 ($1.83 x 29.634%).

e. Ross does not agree to the net effective rebate amount increasing retroactive to the first day of the month in which wholesale prices increase. Instead, vendor proposes increases take effect the first day of the month following the effective month of the price increase.

f. Ross requires access for audit purposes to State records and documents related to the purchase of infant formulas by the State WIC Program.

g. Ross requires a certification with each monthly infant formula rebate invoice attesting to the State's monitoring/enforcement efforts that is signed by an elected official or the State's Attorney General.

h. Ross requires the State to negotiate or add other new products if they qualify for WIC by USDA.

Ross Laboratories was obviously not interested in the Texas business.

Texas officials have just completed our review of the bid documents and have awarded the bid to Mead Johnson Nutritionals.

Although Texas has fortunately received a bid that virtually mirrors our current rebate level, whether true competition existed for the WIC business in Texas appears questionable.

Under current bid specifications and the $1.25 per can bid Texas received from Mead Johnson, we will be "held harmless" from caseload reductions as well as rising formula pricing for FY91-92 due to formula rebates. Had our best bid been 89 cents per can (Wyeth's bid in Texas) we estimate that 44,177 fewer women, infants and children per month would be served in FY91.

Summary

(1) The national WIC Program remains seriously underfunded.

(2) The Texas WIC Program needs an additional $17.8 million in food funds for FY91 to regain our FY90 target participation of 350,000 women, infants and children per month. This includes funds to restore cheese and other food package reductions for younger children.

The Texas WIC Program requests funding to expand our participation to 400,000 per month or 30% of our potentially eligible population. This would require an additional $36.8 million in food funds including the restoration of cheese and other food package reductions for younger children.

(3) The underserved status in Texas is critical. Three out of every four potentially eligible participants cannot be served due to lack of funds.

(4) We cannot continue to compromise the effectiveness and desirability of the program by further reducing the food package in Texas.

(5) We cannot continue to eliminate services to the lower priorities of participants. The program was designed to prevent the occurrence of health and nutrition related problems during those critical times of growth and development. Our failure to fund this aspect of the program all but ensures the health and nutritional status of our high risk population will regress to the point that clinical signs of inadequate nutrition are present.

(6) The WIC Program is a cost-effective program which for under $40.00 per month is producing healthier children for our nation's future. In addition to the food package, we are providing critical individual and group nutrition counseling and providing an access into other critical services such as prenatal care, well child care, immunizations and family planning for this cost.

(7) The WIC Program has proven to save money in hospitalization costs by improving the health of our children.

(8) I would like to close by urging that you move closer to full funding of the WIC Program. At this point I don't necessarily mean entitlement because the priority system works well. However, there is a large disparity among states across this country in their ability to serve their respective WIC population. While some states can only serve one-fourth of their WIC population, others can serve over three-fourths. The states and USDA addressed this problem with the cooperative development of an "equity" funding formula in 1983 and a "targeted/equity" funding

formula in 1988. I endorse these formulas because they move some growth money in the right direction and have since 1983. The problem is there is insufficient money to move. It has been seven years since the equity funding concept was adopted and we still have this wide disparity. It is in regulations and USDA policy, and properly so, that caseload cuts when necessary be applied across a state by priority of clients served. It should also be so across the country. A priority IV eligible pregnant woman should not be penalized because she lives in a state which can only serve one-fourth of its potentially eligible population while another state is enrolling all priorities.

I am not advocating taking money from those states. I am urging that as you consider additional growth funds that you also consider ways to achieve greater equity among the WIC population in the grossly underfunded states so as to reduce the inequities that sadly now exist.

Thank You.

Attachments.

ATTACHMENT I

FY90 FUNDING ESTIMATES
DECEMBER, 1989

FY90 Federal Food Funds	$	114,160,048.00
FY90 State Food Funds		5,202,099.00
FY89 Carryforward		1,200,223.00
FY89 Estimated Texas Share of Reallocation		1,500,000.00
Total Available Food Funds FY90	$	122,062,370.00
Divided by 12 months		12
Monthly Food Funds Available	$	10,171,864.00

Divided by FY89 Average Food Package Cost	$27.97	353,671	participants served per month
Divided by FY90 Projections at 4% Inflation	$29.09	349,669*	" " " "
Divided by FY90 Projections at 4 1/2 Inflation	$29.23	347,994	" " " "

*Estimates Used to Project FY90 Caseload Levels Upon Entry into FY90

FY90 FUNDING ACTUAL
JUNE, 1990

FY90 Federal Food Funds	$	114,160,148.00
FY90 State Food Funds		4,083,648.00
FY89 Carryforward		1,200,223.00
FY89 Texas Share of Reallocation		1,160,818.00
Total Available FY90 Food Funds	$	120,604,837.00

ATTACHMENT II

% FOOD INFLATION IN TEXAS BY WIC FOOD

Sept. 1989 Average Food Cost	$29.08
Jan. 1990 Average Food Cost	$31.93
Percent of Change	9.80%

	Sept.	Oct.	Nov.	Dec.	Jan.	% Increase/Decrease Sept./Jan.
1/2 Gal. Milk	1.26	1.28	1.31	1.37	1.41	11.90%
Evap. Milk	.63	.62	.60	.61	.64	1.58%
1 LB. Cheese	3.24	3.32	3.38	3.44	3.49	7.72%
32 oz. Infant Formula	2.46	2.47	2.53	2.58	2.58	4.87%
13 oz. Infant Formula	1.68	1.69	1.74	1.79	1.80	7.14%
12 oz. Cereal	2.11	2.11	2.12	2.12	2.14	1.42%
8 oz. Infant Cereal	.87	.87	.87	.87	.87	-0-
46 oz. Juice	1.50	1.50	1.49	1.49	1.51	.67%
1 Doz. Eggs	1.05	1.03	1.10	1.15	1.25	19.05%
18 oz. Peanut Butter	2.29	2.29	2.34	2.30	2.29	-0-
1 LB. Dried Beans	.63	.60	.60	.61	.61	<3.17%>

Attachment III

Estimates of Available Federal Funds for FY91

House/Senate Budget Proposal $2,361,000,000
NAWD Proposal $2,403,000,000
Texas prorata share based on FY90 Allocation of Federal Funds -
Total Allocation - 7.01%
Food Allocation - 5.37%
Admin. Allocation - 1.64%

Estimated Federal Grant based on House/Senate Proposal:
Total - $2,361,000,000 x 7.01% = $165,605,100
Food - $2,361,000,000 x 5.37% = $126,785,700
Admin.- $2,361,000,000 x 1.64% = $ 38,720,400

Texas Contribution to Regional Discretionary Fund =
10% of Federal Admin. Grant:

$38,720,400	$38,720,400	
x 10%	($ 3,872,040)	
$ 3,872,040	$34,848,360	Est. Guaranteed Fed. Admin. Grant

NAWD Proposal:
Total - $2,403,000,000 x 7.01% = $168,450,300
Food - $2,403,000,000 x 5.37% = $129,041,000
Admin.- $2,403,000,000 x 1.64% = $ 39,409,200

Texas Contribution to Regional Discretionary Fund =

$39,409,200	$39,409,200	
x 10%	($ 3,940,920)	
$ 3,940,920	$35,468,280	Est. Guaranteed Fed. Admin. Grant

Estimated FY91 available State Funds:

FY91 State	$5,591,639
Less Farmers Mkt.	125,000
	$5,466,639
Less FY90 Shortfall *	$?
State Funds Available For FY91	$5,466,639

State Funds distributed between Food and Admin. on same proportion as Federal Grant:

Food	Admin.
$5,466,639	$5,466,639
x 78.44%	x 21.56%
$4,288,032	$1,178,607

Total available FY91 Funds under both proposals:

House/Senate Proposal: Federal Food Grant (Est.)	$126,785,700
Add: State Food Grant	$ 4,288,032
Total Est. FY91 Food Funds	$131,073,732
NAWD Proposal: Federal Food Grant (Est.)	$129,041,000
Add: State Food Grant	$ 4,288,032
Total Est. FY91 Food Funds	$133,329,032

*Should Texas experience a shortfall in FY90 food funds, it will be covered by FY91 State Funds.

PREPARED STATEMENT OF LAURIE TRUE

My name is Laurie True. I am a food policy advocate and public health nutritionist for the California Rural Legal Assistance Foundation. CRLA Foundation has been an advocate for the WIC program in California since the program began in our state, working on behalf of participants and local providers to improve and expand the program.

Just a few months ago, I could have told a very happy WIC story. California WIC has been enjoying a period of rapid expansion, fueled by the highest per-can rebate in the country ($1.70 per can, generating over $7 million in additional revenues per month). California's caseload grew by over 30 per cent during 1989. Formula rebates allowed the program to add 110,000 participants since the program was implemented in January 1989. We have been excited and gratified to see so many needy participants added to the program after years of very slow growth.

Unfortunately, our celebration was shortlived. Since April, California WIC has been in crisis. The program is now shrinking rapidly, and is slated to drop 11 per cent of its caseload by October 1. This is a tragic step backwards for WIC.

I would like to describe the nature, extent, and impact of the California WIC crisis, with particular emphasis on the way the caseload cuts and food package reductions is affecting local agencies and WIC families in our state.

Extent of the Cuts in California

The California WIC program anticipates a budget shortfall of approximately $9.6 million by the end of the fiscal year.[1] State WIC staff estimate that 75 per cent of the problem is due to food cost inflation and 25 per cent of the problem is due to overenrolled local agencies. The State Department of Health Services is following a three-part strategy to avoid a deficit:

1. Reduce participation. From a high in March of 482,000 participants, California must terminate 53,000 participants in order to reach a target caseload of 429,000 by October 1.[2]

- All local agencies have been instructed to terminate all Priority 4, 5, and 6 participants when they come in for

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1. The original projected deficit was $14.5 million. However, a more recent analysis (May 10, Department of Health Services) estimates the deficit to be $9.653 million. The deficit projections will change monthly, dependent on caseload counts and new food cost estimates.

2. These figures were supplied by the State Department of Health Services staff at a hearing in the California Assembly Ways and Means Committee, on May 2, 1990.

recertification, which is expected to reduce caseload by 26,000.

- In addition, those agencies who are serving more participants than their allocated amounts are expected to freeze all enrollments and recertifications necessary to bring their caseload down to the levels they are contracted to serve. This will reduce caseload by about 22,000.

- Finally, in a highly controversial action, the state has ordered many agencies to freeze enrollments of higher priority (Priority 1,2 and 3) applicants, to the levels served in March 1990, in order to achieve a further reduction of 5,000.

2. Reduce benefits. The state estimates that $6.05 million can be saved by completely **removing the cheese vouchers** from the packets given to participants each month. Highly vulnerable groups, such as pregnant teens, underweight pregnant women, and lactose intolerant participants will still be able to get the cheese, although the logistics of these exceptions are somewhat complicated. An additional $1.18 million will be saved by **removing one juice voucher** from older children's' packages.

3. Procure a state bailout. Despite caseload cuts and voucher "tailoring", the WIC program may still face a projected $1.6 million shortfall. Pending the Governor's approval in the next few days, a budget **line-item transfer** of up to $2 million will offset this shortfall, using unspent funds from another program

California's Dubious Distinctions

This strategy has earned California WIC some dubious distinctions. To my knowledge, even using the official figures, California WIC

--is cutting more participants off the program than any other state;

--is the only state to be removing cheese entirely from voucher packages of pregnant women; and

--is the only state to take the drastic measure of freezing enrollments of Priority 1 and 2 applicants in some agencies. These priority groups include pregnant and breastfeeding women and infants at medical risk.

Even before the deficit was discovered, California's WIC program lagged behind other states in its ability to meet the need. The Department of Health Services estimates that there are over 1.2

million women, infants and children in need of WIC benefits. With a May caseload of approximately 431,000, only 36 per cent of California's eligible women and children are being served. Some 733,000 participants are shut out of the program due to limited funding. **California's percentage of need being met is one of the lowest in the nation. Only nine other states have lower rates of WIC coverage.** Legislative attempts to supplement our federal grant with state funds, as happens in fifteen other states, have been repeatedly blocked by the current administration.

Unprecedented Demand for WIC in California

The need for WIC expansion in California is extremely critical. The demand for the program has overwhelmed many local agencies. The demand stems from a rising birth rate, large numbers of immigrants and refugees, growing poverty among families with children and foster children, and the highest teen pregnancy rate in the county. Also, more people are being referred to WIC, thanks to slow but noticeable improvements in the perinatal care system.

As soon as the rebate funds began flowing in January of last year, local agencies opened their doors, and new participants streamed in. In fact, the local programs almost immediately began overflowing. From October to April, the program as a whole was overenrolled by an average of 102 per cent to 104 per cent of the target caseload. In March, 40 out of 82 local agencies were overenrolled, some by as much as 15 per cent and even 36 per cent.

Local agency directors have had to cut caseload before, and they can usually do so by a stepwise restriction of enrollments among lower priority applicants, allowing the program to shrink by attrition. This time, however, their techniques did not work, because so many of the new cases were high-risk pregnant women and infants.

In San Diego, one local agency has not enrolled any applicants beyond Priority 3-C for the past five years. In October, the agency terminated all Priority 3-B participants, and in March, all Priority 3-A participants (medically at risk children) were cut, in an effort to meet the target. This month, the agency has 1,000 infants (Priority 1 and 2) on a waiting list, unable to serve them. With formula prices running at about $2.00 per can in San Diego stores, mothers who can't afford formula often resort to using milk or sugar water for their infants, which is very dangerous.

Orange County's WIC program faces a similar situation, and the local food bank has set up an emergency formula donation campaign to assist families turned away from WIC.

Impact of the Cuts in California

Impact #1: The "C" will be taken out of WIC.

In Contra Costa County, no children older than three, even with medical risks, have been able to get into the program since last October. Staff report terminating a child with leukemia, one with cerebral palsy, and many cases of anemic children. Last week, a three-year old boy with severe milk allergies was terminated. This toddler has been drinking soy-based formula since birth, and will no longer be able to get help from WIC to purchase this expensive item. His mother will probably use cheaper, less fortified alternatives, with negative nutritional consequences.

The WIC program is intended to serve women, infants, and children. The current crisis will further reduce the number of older children served by the program. Many local agencies, particularly those in high-need urban areas, have not served **any** children over 18 months, regardless of risk, for years. By September, with very few exceptions, this will be the norm statewide.

The assumption built into WIC's priority system is that pregnant women and infants are at higher risk. However, children under the age of five are also very vulnerable to nutrition-related health problems. In California, one in five of these children, and close to half of minority preschoolers, live in worsening poverty, which means their families cannot afford an adequate diet. Preschool children cannot obtain school lunches and breakfasts, and have very limited access to meals offered by Head Start and other child care programs. Many eligible poor families are not participating in Food Stamps, many are not eligible, and those who are recipients have difficulty obtaining a nutritionally adequate diet with the coupons.

As a result, food pantries and soup kitchens across the state report that more and more families with young children are coming to them on a regular basis for food. Many soup kitchens have begun serving milk instead of cheap juice mixes and coffee, in order to make sure that the many children who come in get something nutritious. This is not an acceptable way to feed hungry children. Children in rural parts of the state do not even have these agencies to turn to, since soup kitchens and food banks are not as developed and sophisticated in rural counties.

In Sacramento County, a foster mother caring for a 14-month old with Down's Syndrome was told last week that her foster daughter could not participate in WIC due to restricted caseload. This girl has special needs that cry out for the counseling, referral, and monitoring that WIC can provide. Her foster mother was referred to a local pantry, but

the food she got--miscellaneous canned and prepared foods--was completely inappropriate for a 14-month old with special needs.

Above and beyond the food benefits, WIC is often a key source of continuing care and support for families with children with nutrition-related health problems. Frequent contact with WIC nutrition staff for assessment, counseling, and referral, are extremely important to these high-risk pre-school children, in order to treat and prevent worsening of their conditions. These services will not be available to thousands under the current reductions.

Impact #2: Food benefit reductions could compromise WIC's effectiveness.

In Los Angeles, local WIC agency staff are having a difficult time bringing themselves to delete cheese from pregnant women's' WIC voucher packets. They have been told to make exceptions for underweight women, teenagers, and other groups. In practice, however, determining these exceptions is difficult, since detailed histories are not readily available. Furthermore, those who don't fit into any of the exception categories are in obvious need of as much nutritious food as possible, since they are pregnant and hungry.

We are extremely concerned over the long-term impact of the State's decision to reduce the amount of food given out to WIC participants. Reducing the WIC food package is basically an economic measure of last resort. When it became clear that the California's budget would not provide the sums needed for a full bailout of the WIC deficit, this extraordinary step was taken in order to avoid terminating large numbers (170,000) of participants over a four-month period, which was the original proposal. However, the food package cuts sets a very dangerous precedent which must not be allowed to continue beyond the immediate crisis.

Despite the fact that these food package reductions were clearly made in order to save money (over $7 million), California WIC staff have produced nutritional justification for the food package reductions, based on the availability of milk to substitute for the calcium lost by removal of the cheese.[1] However, the dietary rationale is open to serious question, since it is based on criteria for a low-risk, healthy population, and assumes WIC participants have access to a wide range of expensive substitute foods.

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[1] Furthermore, the dietary justification assumes that local WIC agencies are using newly printed vouchers, which allow for purchase of 2 pounds of cheese. However, it has come to our attention that many agencies are still using up older edition vouchers, which have 3 pounds of cheese allowable. Removing the cheese from the old vouchers leaves inadequate substituted milk.

All the studies that have evaluated WIC's effectiveness in reducing low birth weight and infant mortality have been performed using the full WIC food package for pregnant women. California is already experiencing an increasing incidence of low birth weight babies. Reducing calories, protein, calcium and other vital nutrients from California's WIC package will dilute the effectiveness of the program and lead to increased health care costs further down the road.

Aside from the nutrition issues involved, USDA regulations are clear that "food package tailoring for administrative convenience or cost reductions is prohibited"[1]. And yet, this is clearly what is happening around the country, with the apparent blessings of USDA. Although we have been assured by Department of Health Services staff that the current food package modifications are to be implemented only during the rest of the fiscal year, we are worried that, absent fiscal relief, the food package cuts will be considered the better alternative to cutting people completely off the program, and will thus will continue.

Impact #3 Some high-risk applicants will be denied participation, and their health will suffer.

In Solano County, the WIC program is not enrolling anyone at the present time, in an effort to cut caseload. If pregnant women comes in today and inquires about enrolling, they will be told that they cannot get a WIC appointment until August. Many of these women will deliver their babies without having been on WIC at all. Meanwhile, the waiting list for prenatal care in this county is now four months, so these women will be without any source of care during crucial period in their baby's development.

The WIC priority categories 1, 2 and 3 contain those participants who are at highest risk of poor birth outcomes or deteriorating health. Pregnant women with conditions such as poor weight gain, toxemia, gestational diabetes, hypertension and anemia are in this category, as well as pregnant women who have had previous problems such as low birthweight babies, and other obstetrical complications. Pregnant women with substance abuse problems and who are HIV-infected also qualify.

In addition, high-risk lactating women badly need the extra nutrition and counseling support that WIC can provide as they recover from pregnancy and birth and initiate and sustain breastfeeding. Finally, infants and children who are suffering from serious medical conditions such as low-birthweight, failure to thrive, diarrhea/dehydration, anemia, feeding problems and allergies, parasites, and other nutrition-related problems fall into these categories.

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[1] Final rule of September 1, 1981, 46 FR 43824.

It is short-sighted, fiscally unsound and basically unacceptable to deny WIC benefits to **anyone** in this group of participants. WIC has been proven again and again to prevent poor birth outcomes, lower infant mortality and morbidity, and improve nutrient intake. By doing so, WIC saves money that will have to be spent in hospital emergency rooms and neonatal intensive care wards. Clearly, by implementing these caseload cuts to save money in the short term, the State of California--and the rest of the nation--will eventually have to pick up a much bigger tab.

Impact #4. There will be long-term damage to the WIC program as a whole.

In every California county, the WIC program is a part of the community, integrated into the health care and social services system. WIC is a "user friendly" program, where participants feel supported and respected. WIC's success is partly due to this factor, along with the food and counseling participants receive. Terminating and turning away participants will create long-term damage to the current positive regard and trust that they have for WIC. Past experience has shown that large, sudden cuts have a reverberating effect in participation as a whole, which takes years of outreach and public education to undo.

Impact #5: California's perinatal care system will be damaged.

WIC is an important adjunct to health care services. In recent years, several federal and state measures to improve prenatal care to low-income, high-risk women have been implemented. These include raising income eligibility, streamlining paperwork, expanding outreach and coordination, and providing early, comprehensive care at the clinic level. WIC plays a key role in this improved health care "safety net", acting as a vanguard program, plugging women into the system using referrals and encouragement. Improvements are beginning to be felt in California communities. Local WIC staff report more prenatal applicants coming in due to better referrals and outreach.

By freezing enrollments of pregnant women to the March levels, improvements in perinatal care will suffer a severe setback. Studies have shown that most women find out about both WIC and prenatal care by word of mouth. Despite the fact that <u>some</u> women can still be enrolled, word of WIC denying benefits even for a few months or to a limited amount of women, will travel fast, and have a strong dampening effect in new applications. It is extremely unfortunate that, just as California's perinatal care system was showing signs of improvements, it will suffer serious damage.

Recommendations

• WIC needs immediate fiscal relief via a Supplemental Appropriation for the remainder of FY 90. Unless this legislation and funding is secured immediately, it will be too late to reverse the caseload and benefit reductions now being implemented in California.

• Funds for WIC's FY 91 allocation must be substantially increased. Both the House and Senate need to appropriate and allocate the full increase of $150 million over current services assumed for WIC in the House Budget Resolution.

• In the long term, Congress needs to allocate enough WIC funding to allow the program to serve all who are eligible.

• The practice of reducing WIC supplemental foods in order to realize cost savings during a fiscal crisis needs to be scrutinized, both from regulatory and nutritional standpoints.

California WIC Monthly Participation

Year/Month	Caseload
1987	
'87 Average	270,946
1988	
July/August	318,421
October	333,229
November	336,795
December	325,068
1989	
January	350,307
February	345,617
March	378,153
April	395,224
May	405,626
June	430,705
July	436,724
August	458,379
September	462,066
October	471,354
November	484,036
December	444,961
1990	
January	483,925
February	472,912
March	480,534
April	447,282
May	431,109

Other California WIC Facts

Total FY 90 Federal Grant: $195,555,390
FY 90 Target Caseload: 458,766

Food Expenditures (estimated): $154,808,228 (79.16%)
State Nutrition Services and Administration: $7,197,786 (3.68%)
Local Nutrition Services and Administration: $34,359,869 (17.57%)

Rebate Earned in FY 89: $48.2 million
Rebate Earned in FY 90 (estimated): $82.9 million

Estimated Breakdown of March '90 Participation, California WIC

Priority	Participation
1	208,284
2	66,807
3	180,936
3A	104,745
3B	51,791
3C	24,400
4	3,570
5	22,359
6	540

Source: Department of Health Services WIC Branch, May 1990

[Whereupon, at 12:20 p.m. the Task Force adjourned.]

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